Reading (and writing) between the lines

Gold, K.I.

Publication date:
2013

Document Version
Publisher's PDF, also known as Version of record

Reading (and writing) between the lines:

Narrative as relational resource for alternative stories of healthcare practice

Karen Gold

"we are left to ponder the radical possibilities of storytelling and the relational moment"

Reading (and writing) between the lines: narrative as relational resource for alternative stories of healthcare practice

Proefschrift

ter verkrijging van de graad van doctor aan Tilburg University op gezag van de rector magnificus, prof. dr. Ph. Eijlander, in het openbaar te verdedigen ten overstaan van een door het college voor promoties aangewezen commissie in de Ruth First zaal van de Universiteit op maandag 13 mei 2013 om 16.15 uur

door

Karen Irene Gold

geboren op 30 september 1961 te Toronto, Canada

Promotores:

prof.dr. S. McNamee

prof.dr. J.B. Rijsman

Overige commissieleden:

prof.dr. A. Katz

prof.dr. M. Bertau

prof.dr. I. Todorova

prof.dr. K. Gergen

I like to think of writing as a way of bringing something that has passed away back to life.

Michael D. Jackson, 2012: 93

I, and most people I know, live rough-draft lives. We write our lives, and our lives rewrite us: the trajectory of our lives is not clearly discernible, and, when it is, it appears more like a scatter than a line and more like a series of starts and stops than a continuous progression... Indirection is the way we find direction: only rarely do we live by the straight and narrow, travel the direct route, or know where we're going before we begin. Ours are not single-copy, single-voice, or single-identity lives... Most writers I know... understand ourselves and our writings as rough drafts... as collages that various people and experiences have written all over, and as multimedia hypertexts. We write nothing alone since we see ourselves as multiple and our texts as alive with people we know and have read, remembered, imagined... Creativity and contingency, rather than certainty, motivate us to write.

Tilly Warnock, 2000: 34-5

Some of my colleagues in the biomedical world want to explain us entirely in terms of our genes and our physiology. I resist that. While I certainly see the value of this biomedical model, which is so powerful in our moment, I really still want to embody, in my own work, this ancient notion that language and how we tell the story of who we are – particularly of how we suffer – and how critically important that is as a definition of being human, of living as a human being.

Rafael Campo[1]

[1] Accessed 5 April 2013 from www.themorningnews.org/article/birnbaum-v.-rafael-campo.

Contents

Illustrations

Note on front cover image: The process of writing this thesis can be likened to the creation of a quilt as I have been working with the "odds and ends" to piece together something new. Quilt-making is a good metaphor for a dissertation comprised of different stories and "liminal spaces where knowledge never arrives but is always on the brink." Most importantly, it "reflects the very way we experience the world with objects given meaning not from something within themselves, but rather through the way we perceive they stand in relationship to one another." (Robertson in Butler-Kisber & Poldma, 2010.)

Many of the images in this document were drawn from *PatientVoices* and *Nurstory: The Role of Personal Narratives in Supporting Reflective Practice for Nursing Doctoral Students and Practicing Healthcare Providers*. Both projects document the stories of patients and healthcare professionals through digital storytelling. All on-line images were accessed 30 March 2013.

Acknowledgements

Many thanks goes to the **Taos Institute** where I found a unique home in which to pursue PhD studies and deepen my appreciation of relational and constructionist sensibilities. I have felt 'at home' in their gatherings since I began the program; their conferences and workshops were a highlight of this whole process as was meeting new colleagues and making new friends. I feel so lucky that I stumbled on this Taos/Tilburg program which allowed me to pursue a PhD while working full-time, and truly supports an approach to inquiry rooted in practice. Many thanks to my readers and committee members: John Rijsman, Kenneth Gergen, Arlene Katz, Marie-Cecile Bertau and Irena Todorova who supported a creative approach to inquiry and whose comments created further pauses for reflection.

Thanks to the **narrative medicine** (**healthcare humanities)** communities in which I have found a like-minded tribe interested in bringing together narrative sensibilities, clinical practice and education. Reading Rita Charon's *Narrative Medicine* several years ago started me on the journey of thinking more deeply about how practice unfolds in stories. The workshops I attended at the Program in Narrative Medicine at Columbia University, where I had the opportunity to read, write and share with others, were another highlight of this journey and bolstered my belief in the power of narrative writing.

Special appreciation and thanks goes to my thesis advisor (and mentor) **Sheila McNamee** for her support and guidance throughout this entire process. When I first met Sheila I felt we were destined to be a good match – and it proved to be true! Sheila's commitment to collaborative conversations, and the value of knowledge from everyday practice, helped me stay on track when I was having trouble finding my way through. Our phone calls, email correspondence and face-to-face meetings were important touchstones throughout this process and Sheila held a place in my internal dialogue as an 'imagined reader'. I received many pieces of good advice from her – including the notion that you never know where inspiration will come from.

Women's College Hospital has been my professional home for the last twenty years. Thank you to my friends, colleagues, clients and students who have helped shape my sensibilities and whose voices appear in this text in so many different ways.

Thank you to my parents **Syrl and Harvey Gold** for instilling in me the value of education, and for supporting me in countless ways through personal, professional and academic pursuits. My mother's interest in the arts has long been a presence in my professional life (starting with the quilt she made for my first social work office) and their steady support has been a great anchor throughout my life.

I am grateful to my husband **Alan Cantor** for providing hands-on support throughout this process including meals, computer assistance, and countless hours of formatting and copy editing. The computer shortcuts sure made my life a lot easier. His moral support throughout this process has been unwavering – ever since we found the Taos/Tilburg PhD Program on-line one evening and he proclaimed "this is the program for you." Most of all, he has been a sounding board for endless conversations about narrative and the trials of thesis writing as my work took over our lives – and our dining room table. He was a firm believer in my ability to finish – even when I wasn't so sure!

I dedicate this thesis to the memory of my grandmother **Rose Goldhar** who passed along many valuable lessons in life (including the pleasures of sleeping on two king size beds pushed together!) and to my son **Dylan Gold** who, as I complete my dissertation, is graduating from high school and about to begin university. I have appreciated his patience at the countless hours I spent hunched over the computer. My hope is that he discovers much to challenge and inspire him in the years ahead. The best 'words of wisdom' I can pass on is to point out that huge projects (like writing a dissertation) are daunting and require enormous perseverance. As Anne Lamott (1994) succinctly illustrates in this story:

> Thirty years ago my older brother, who was ten years old at the time, was trying to get a report on birds written that he'd had three months to write, which was due the next day. We were out at our family cabin in Bolinas, and he was at the kitchen table close to tears, surrounded by binder paper and pencils and unopened books on birds, immobilized by the hugeness of the task ahead. Then my father sat down beside him, put his arm around my brother's shoulder, and said, "Bird by bird, buddy. Just take it bird by bird."

Abstract

Beginning with a personal narrative from my practice, this thesis is an exploration of narrative moments in healthcare practice. Informed by narrative inquiry, autoethnography and relational constructionism, my approach is characterized by curiosity, multiple theoretical and narrative voices and the co-construction of meanings. I draw from the concept of writing as a method of inquiry, poetic inquiry as well as dialogical approaches to inquiry, to construct a frame for inquiry. I approach my study of narratives as a way to create generative conversations about the everyday meanings of practice. I thread myself into the conversation by using my own poetic responses, stories, reflections and analysis of others' narratives.

I explore practitioner narratives, in the form of poetry and short stories, as a strategy for making visible the legacy of biomedical discourses on healthcare practice and professional identity, as well as providing more richly drawn alternative accounts of practice. Drawing on the concept of liminality – or in-between spaces – to illuminate marginalized aspects of healthcare practice, I explore those places in practice and professional identity characterized by uncertainty, ambiguity and not-knowing.

In reflecting on the implications for health professional education, I discuss the use of narrative in creating spaces for critical reflection of practice ethics. Drawing on my teaching experiences and ideas about relational teaching practices, I examine poetry as a means to explore (and resist) conventional notions of ethics and professionalism which do not honour the sometimes messy relational dimensions of practice.

Finally, I reflect on the writing of this thesis within the context of narrative inquiry and my own personal/professional journey, and consider opportunities for further conversations about practice narratives. In particular, I reflect on the role of narrative as practical resources for building a preferred future – or counter-story – that acknowledges otherwise marginalized aspects of day to day practice and provides a means to honour relationality and mutuality in practice.

Chapter outline

Chapter 1: I situate myself, and my interest in this topic, in my own personal/professional journey. I outline my philosophical approach to inquiry, which is informed by narrative inquiry and relational constructionism, as well as the focus on narrative writing by healthcare professionals as a way to explore marginalized aspects of practice and professional identity.

Chapter 2: Beginning with a personal narrative "How and Why We Speak: Reflecting on Loss and Connection" I explore narrative inquiry and writing in professional practice. Re-visiting and reflecting of this story leads me to a fuller examination of concepts related to narrative and narrative inquiry, including notions of narrative 'truth', issues regarding voice in narrative writing, the ethics of writing about practice and the emerging role of personal narrative and reflective narrative writing in professional and scholarly work. Following the reflections on my own story and narrative inquiry, I turn my attention to fleshing out my conceptual approach. I discuss the relationship of knowledge to day-to-day practice, the importance of reflexivity in inquiry, and the role of narrative in creating possibilities for research on everyday practice.

Chapter 3: For the purpose of my discussion, I highlight principles of relational constructionist inquiry including the critique of individualist ideas about knowledge and identity, and the emphasis on collaborative meaning-making. I draw heavily from the social constructionist metaphor of 'inquiry as conversation' and the idea that knowledge is generated out of everyday practice. I also discuss the importance of a self reflexive stance, a critical examination of taken-for-granted practices and the role of language processes in creating meaning. In building on notions of dialogical narrative analysis, I present three ideas to construct a framework for inquiry: 'writing as a method of inquiry' which highlights the role of writing in constructing meaning; 'social poetics' which emphasizes the notion of resonance; and 'relational poetry' which highlights the potential for dialogue through poetry. These concepts comprise the basis for my approach as I weave narrative texts into the discussion to explore issues in professional practice.

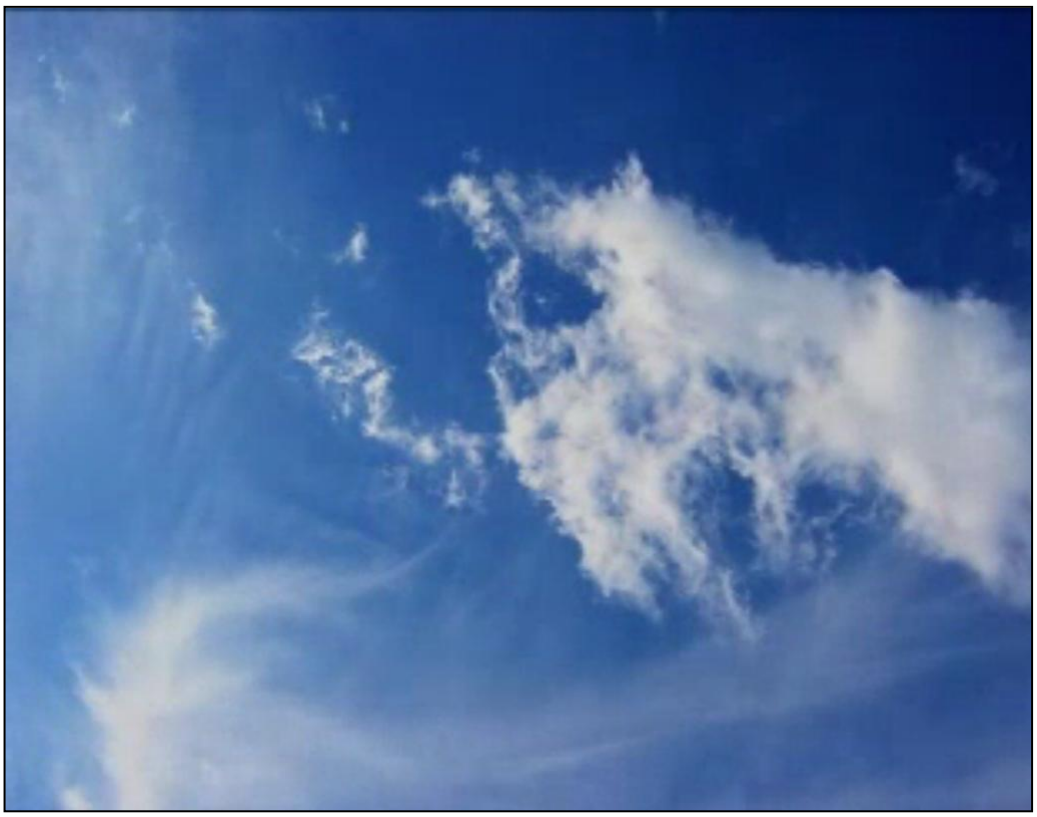
Chapter 4: I turn my attention to healthcare practice. First, I explore the impact of biomedical discourses on contemporary practice with particular attention to assumptions about objectivity and dualistic/mechanistic views of the body and illness. I then examine narrative approaches that seek to challenge the privileging of biomedical discourses and honour the intersubjective dimensions of practice. This brings me to an examination of narrative reading and writing as a strategy to explore the often neglected relational aspects of practice and the everyday experiences of patients and practitioners.

To enrich the examination of narrative reading and writing in healthcare practice, I draw on the concept of liminality. While there are many ways to analyze narrative writing by healthcare practitioners, I consider the concept of 'liminality.' After a brief discussion on the application of liminality to organizational life and the experience of illness and care, I explore various aspects of professional practice and identity as 'in-between' spaces. In particular, I examine shifting professional identities and borderland spaces in everyday practice and the ambiguous space between knowing and not-knowing. Narrative writing constitutes an alternative story of practice characterized by uncertainty, indeterminacy, ambiguity and mutuality.

Chapter 5: In the final chapter, I discuss implications of narrative in health professional education and conclude with my final (but not finalizing) reflections on this inquiry. I discuss the use of narratives in health professional education, and then turn to my use of poetry with students to foreground tensions in professional practice. In reflecting on the power of poetry to explore relational complexities in practice, I integrate discussion of relational teaching practices and the role of narrative in collaborative meaning-making. In this view, poetry is a way to 'see differently'– and a resource for resisting dominant conceptualizations of practice and professional identity.

In the final section, I reflect on this thesis journey through the lens of narrative inquiry, and discuss the possibility of narrative to generate different kinds of conversations in healthcare. In wanting to promote an inclusive approach to inquiry, I offer suggestions for integrating narrative writing with other forms of social science research to provide multi-dimensional accounts of everyday practice. I reflect on the role of narrative in building a preferred future – or counter-story – for healthcare practitioners that acknowledges uncertainty, ambiguity and mutuality.

1. Introduction: background notes



This is a story about story telling and a narrative about theorizing. Like the very notion of identity that it attempts to describe, this text is provisional.

Marcus O'Donnell[2]

There is no theory that is not a fragment, carefully prepared, of some autobiography.

Paul Valery[3]

---

[2] Accessed 26 March 2013 from http://marcusodonnell.com/teaching/philosophy.htm.

[3] From Denshire & Ryan, 2001.

Situating myself

> What narrative had taught me was that if I, as a [practitioner, educator and researcher], could not come to terms with my own story, how could I come to terms with others' stories? (Maggisano, 2008: 6)

The focus of this thesis is an exploration of narrative reflective writing by healthcare practitioners. My interest in this topic can be traced back to my English literature and critical theory studies as an undergraduate student in the early 1980s – although I didn't make the connection until part way through my thesis research as I was sitting in a narrative medicine workshop at Columbia University – and reflecting on how I got there. My decision to become a social worker was in no small part a desire to shift from theory to practice; to move from what former social worker and sociologist Carolyn Ellis calls 'knowing to doing' (1997: 122). As a social worker I found myself drawn to practice approaches (like narrative therapy) which are informed by principles of collaboration, relational sensibilities and the "linguistic" turn in social sciences.

In this sense, I have been using 'familiar skills in unfamiliar places' by bringing "conversational resources" that are familiar to me in one context into another set of relationships and situations (McNamee, 2004: 238). While in some ways, the process of writing this thesis has felt like a return to my early days studying English literature, and my training as an English teacher, my perspective on practice and inquiry has been shaped by over twenty years as a clinical social worker, therapist, social work instructor and most recently as an educator in a hospital setting.

In this way, my thesis brings together my interest in a more relationally-oriented practice with a sense of curiosity about how narrative, and specifically language, shapes our understanding of what is 'real', and ultimately, what is possible. Arts-based and narrative approaches to health professional education have been considered somewhat marginal, while at the same time viewed as a useful way to engage the 'moral imagination' (imagining what might be), promote more compassionate practice, and provide alternative representations of illness and caregiving (Kinsella, 2007: 40). My thesis is primarily a meaning-making project – an attempt to make sense of practice – both my own and others – through reflective narrative writing of practitioners.

This inquiry is part of a larger movement to use scholarship and narrative methods to "produce knowledge that will be more attentive to the experiences of service users and practitioners" (Phillips, 2007). While the growing body of literature referred to as 'patient narratives' or 'illness stories') plays an important role in enhancing our understanding of

first-hand accounts of illness and experiences with care, I turn my attention and 'gaze' in this inquiry towards writing by practitioners.

Purpose and focus of inquiry

I situate my thesis within an ongoing conversation in qualitative research on the role of personal narrative in scholarly work, as well as the emerging literature on the role of the humanities in healthcare practice and professional education. Wanting to participate in the ongoing 'circulation' of narratives which, according to medical sociologist and narratologist Arthur Frank (2010) is a key role of narrative researchers, I have 'gathered' practitioner narratives together here to provide rich and nuanced accounts of the complexity and ambiguity of day-to-day practice.

My hope is that this analysis contributes to a re-examination of 'what it means to be a healthcare professional' (Engel, 2008) as well as pointing to the importance of practitioner narrative writing as a way to explore the "everyday rhythms" (Kleinman, 1995) of practice. In this sense, I agree with Harris (2006) that art and literature can be seen as an overlooked form of ethnographic data on practice. Informed by the constructionist notion that language is critical in the shaping of meaning, my intention is to contribute to "the reinscribing of the everyday world of practice into public accounts" (Denshire, 2010) by calling attention to practitioner writing as texts that make visible everyday meanings.

I am interested in making visible background assumptions about professional practice in healthcare – what Foucault understood as 'the great anonymous murmur of discourse' (Monk and Winslade, 2013: 14) as well as marginalized aspects of professional identity that are often submerged under expert-driven discourses of practice. Informed by the idea that narrative opens up possibilities for re-storying practice (McNamee & Hosking, 2012: 52), I have come to view reflective narrative writing by practitioners as counter-narratives – as they offer alternatives to dominant story-lines within healthcare. Such counter-narratives can be defined as "stories hidden in the midst of other stories" or "other possible stories that sit alongside, or behind, or underneath the dominant story" (Monk & Winslade, 2013: 46).

I am particularly interested in those narrative accounts of practice that fall outside "those ways of understanding that are taken-for-granted as 'true' or 'right' and largely go unquestioned" (McNamee, 2009: 62) or "those ever present assumptions about how the world is, how people should be, and how people should respond when the 'rules' are broken" (Monk & Winslade 2013: 40). Interested in how language shapes our notion of what is 'real' by making certain practices visible, and submerging others, I draw on the notion of 'discourse' throughout the thesis which refers to:

> a system of statements, practices, and institutional structures that share common values... discourses sustain a certain world view... discourses do not simply describe the world; they also categorize it. In so doing, discourses bring certain phenomena into sight and obscure other phenomena... because dominant discourses are so familiar, they are taken for granted and even recede from view. It is hard to question them... dominant discourses reflect and are part of the prevailing ideology. (Hare- Mustin, 1994: 19)

The starting point for this thesis is a sense of curiosity, a keen interest in language and poetics, which can be defined as the crafting of new meanings and images with a social emphasis (McNamee, 2000), and an interest in exploring the ways we make meaning *with each other*. While narrative inquiry emphasizes the role of 'story' in the construction of knowledge and identity, relational and constructionist approaches provide the theoretical foundation for my dissertation. In particular, I draw from dialogical approaches that emphasize those 'relational spaces' in inquiry which are concerned with issues of representation, reflexivity and the social dynamics between researcher, subject and text and suggest that the relational dynamics of research take centre stage (Gustavson & Cytrynbaum, 2003). In focusing on those relational moments, I approach healthcare narratives as a form of relational practice and, perhaps most importantly, as 'resources for action' (McNamee, 2012).

In exploring the field of healthcare narrative and narrative inquiry, I am guided by the cautionary words of Arthur Frank (2010) who claims it is not feasible to say anything new about narrative – nor is it wise to try and do justice to the ever growing "thicket of definitional distinctions" in narrative theory and analysis.

> Academics value original contribution. But, as the gateway to Dante's inferno warns those who pass through it to abandon all hope, so the gateway to narrative analysis should caution scholars to abandon all pretence of saying anything original. That does not mean abandoning the hope of saying something useful and interesting that leads people to imagine different possibilities for how their lives are formed and informed – much as a story leads people to imagine different possible lives. (17-8)

Rather, Frank (2010) suggests that the role of a narrative researcher is derived from their "wider lens" which can place different narratives together in meaningful ways.[4] I am drawn to the idea that narrative analysis is about situating any one story within multiple stories, and seeing the linkages (or relational possibilities) between texts. This approach

[4] In thinking about the difference between having a 'wider lens' and 'having the whole story', I agree with Lincoln that if "texts are necessarily partial and situated, then it is a realist pretense to hope that any given text can tell the 'whole story' as multiple stories feed into any text" (in Tierney 1997: 38).

highlights opportunities for new conversations or 'fusions of meanings'. From a relational perspective, the value of narrative research is derived from the researcher's immersion in multiple stories, and their interest in weaving them together, as "this is not more than any participant could say but is more than any participant is currently located to say" (Frank, 2010: 102).

If the primary job of a narrative researcher is the assembling and reassembling of stories so the analysis becomes another 'voice in the polyphony' (Frank, 2010), then my goal is to connect various stories in a meaningful way, as well as put them forward to (new) readers/audiences. By participating in the relational acts of storytelling, I am interested in giving practitioner narratives *practical presence* (Gergen, 2009). This is reminiscent of Wittgenstein's understanding of inquiry : "we do not seek to learn anything new by it, we want to understand something that is already in plain view... our problems are solved, not by giving new information, but by arranging what we have always known" (cited in Shotter, 2010: 207).

Also informed by narrative theorist Jerome Bruner's conception that all stories exist in a landscape of *action* ('what happens'), as well as a landscape of *meaning* (cited in Engel et al, 2008: 107), my intention is to focus on the meanings of our work as storied through practitioner writings. I am interested in what narratives offer us in being able to "infer what it feels like to be in that story world... [and to] create experiences for their audiences" (Mattingly, 1998: 8).

An approach to inquiry

Interested in an approach that is 'accountable to complexity', I prefer to trade in the value of 'not being so sure' and to work in the midst of messiness, contingency, and ambiguity (Lather, 2010). Making no claim to "interpretive authority" (Frank, 2010), I see my own analysis of practitioner narrative as "one of a multitude of possible readings and interpretive paths" (Harris, 2008: 509), and offer my analysis as one "possible interpretation that can coexist among the many that my readers are sure to feel as deeply" (Campo, 2003, 25). In this sense, my analysis is tentative and partial – and open to other readings that exemplify the imaginative and indeterminate nature of narrative inquiry (Cunliffe, 2002: 136).

I am informed by social constructionist theorist Kenneth Gergen's urging to move academic work "out of the house of privilege to write in more generative ways with the intention of creating new conversational openings" (Gergen, 2010: 211). Not interested in perpetuating the dualism between creative writing and formal academic writing

(McKenzie,2007: 25), I draw from a range of theoretical and narrative sources, scholarly work, practitioner writing (including poetry, personal essays and short stories), and autoethnographic reflections through my own narrative accounts of practice. I approach my inquiry as a *series of punctuated layers* that can embody different traditions of communication and create opportunities for conversation among these various traditions (Gergen, 2009).

I am interested in using theory to help me make sense of practice, and agree with cultural theorist Catherine Belsey that the test of a theory is whether it enables us to do something that we could not do otherwise, or helps us read something differently (in Hall & Nel, 2007). I focus on reflective narrative writing in the form of poetry and short stories to embrace 'messy' (partial, fragmented) forms of inquiry (Hudson Jones, 1999), and to invite voices that fall outside biomedical discourses into the conversation more fully.

Bringing together different kinds of narrative texts, such as poetry and storytelling, with qualitative research data, can better answer some of the complex, layered questions that practitioners ponder in day-to-day practice (Transken, 2005). Drawing on the idea that narrative inquiry is a conversation of various voices, rather than an accurate representation of what is 'out there' (Hare Mustin, 1994: 20), my writing has "abstract theoretical moments" and "meditations on big ideas" but is also filled with stories and poetry that allow us "fine-grained analyses of moments of everyday life" (Mattingly, 2010: ix).

Informed by notions of poetic inquiry and writing as a collaborative process, as well as Gergen's (2009) suggestion that one's writing form is a medium that carries an important message, I weave together writing by practitioners with my own poetic responses. I draw on notions of the 'social poetic' and the 'relational poetic' (Shotter, 2010; McNamee, 2000) as a way to conceptualize my responses to others' work and extend the conversations with other practitioners, researchers and writers.

While drawing from a range of narrative writing, I rely primarily on poetry to explore professional practice. Poetry has been used effectively to highlight the experiences of patients, explore issues related to ethics and professionalism, and reflect on tensions and unexamined assumptions in practice ideologies (Nisker, 2009; Butler-Kisber, 2010; Kinsella 2006; Rappaport, 2006; Furman, 2005: Mazza, 1998). Poetry is an evocative resource in qualitative research and has been used in various aspects of the research process including poetry as field research, data analysis and dissemination strategy to circulate research findings to a broader audience.

Poetry is an evocative resource for constructionist inquiry as it is a way make sense of lived experience, a way to engage in a conversation with one's environment, and a mechanism to give voice to that which is not easy to articulate (Raingruber, 2004). Poetry is a powerful method for narrative inquiry as it generates "thick textured descriptions" (McNamee and Hosking, 2012: 47). It is a fitting resource for relational inquiry as "poetry

leads us into the self, but also away from it" (Hirshfield, 1997: 32) and as Ramsey (2011) points out, a unique opportunity to create space for the co-production of meanings.

Laurel Richardson (1992) reflects on her use of poetic devices in qualitative research as a way to convey a narrative. Suggesting that conventions regarding academic writing reflect and perpetuate certain assumptions about knowledge, Richardson encourages us to re-think those textually 'marginal' places where we are able to "ponder lived experience" (125). In moving away from more conventional social science inquiry, she states, "poetic representation plays with connotative structures and literary devices to convey meanings; poetry commends itself to multiple and open readings in ways conventional sociological prose does not" (126).

Poetic inquiry, as a branch of arts-informed research, has been used by academics who are seeking ways to collapse the boundary between creative writing, reflective practice and scholarly work. Perhaps most importantly, poetry calls attention to lived experience as poetry "attempts to reckon with how the everyday world matters and helps us see afresh what is happening around us" (Stewart, 2010: 101).[5]

I chose to use existing poetry in my research as it is accessible and there is a wealth of material available. Constructionist inquiry aims to be sensitive to both local culture and practical concerns and I learned first-hand that "as a social constructionist inquirer [our] original positioning is always open to amendment" (McNamee and Hosking, 2012: 48). When I began this dissertation I was interested in exploring the role of narrative (reading and writing) in healthcare practice and education. While I initially had plans to organize reflective writing groups, solicit narratives from colleagues or use the narrative writing produced in seminars with students as research 'data', I soon realized that using this material for research purposes would be problematic given ethics practices and current discourses in hospital settings regarding confidentiality and conflict of interest.

Inspired by broader constructionist conceptions of knowledge, and the recognition that generating narrative 'data' primarily for the purpose of research was probably unfeasible, I turned to the trove of existing narrative writings (poetry, prose, personal essays, short stories, play scripts) produced by healthcare practitioners and therapists that could provide rich material for my investigation. This material is accessible through published anthologies, literary and academic journals, books of poetry and online medical and healthcare humanities websites. While I had been using these texts for my own reflection and for teaching purposes, I had not thought of them as resources for research. My reading

---

[5] For a fuller discussion of the field of poetic inquiry see *Poetic Inquiry: Vibrant Voices in the Social Sciences* edited by Prendergast, Leggo and Sameshina (2009) and *The Art of Poetic Inquiry* edited by Thomas, Cole and Stewart (2012). See also "29 Ways of Looking at Poetry as Qualitative Research" at: www.ccfi.educ.ubc.ca/publication/insights/v13n03/intro/prendergast.html.

on different kinds of qualitative research (including research on ethnography and the use of texts as sources of knowledge), as well as ongoing discussions with my thesis advisor and colleagues, encouraged me to look towards my own practice, as well as 'found data', as the focus of inquiry. My primary resources were pulse magazine, Hektoen International, the Literature, Arts and Medicine database and the BMJ Medical Humanities Journal, print journals like *The Examined Life: Writing and the Art of Medicine* and *Bellevue Literary Review*[6] as well as memoirs, anthologies of poems and short stories.

To gather a broad range of voices within healthcare, I have included texts (and commentaries) by practitioners from a range of disciplines including: physicians, nurses, social workers, occupational therapists, psychotherapists, educators, dieticians and consultants.[7] While I have attempted to make my investigation as inclusive as possible, it became clear early in the research process that writing by physicians dominates the field of healthcare narrative. Healthcare blog writer Theresa Brown points out in her piece "Calling All Nurse Writers" that there is a 'cultural fluency' (i.e. legitimacy and acceptance) towards physician/writers that still does not exist for nurse/writers (and I would suggest for other healthcare professionals as well).[8] The upcoming conference "Attentive Writers: Healthcare, Authorship and Authority" addresses recent calls for a more inclusive approach to the medical humanities and specifically "questions the authoritative place of the western – traditionally male – physician in our exploration of the humanities/health interface".[9]

While I would acknowledge that our writing is informed by both our personal perspectives and professional identities (Kent, 2008), I have chosen to treat professional and disciplinary categories 'loosely' for the purpose of this inquiry. The focus of this inquiry is not disciplinary differences in narrative writing, so I have decided to follow healthcare

---

[6] *Pulse* is an online resource of stories and poems from patients and healthcare professionals "to talk honestly about giving and receiving medical care... to come together, share our experiences in health care, and explore our common wish for a humane system of health". For more information see http://pulsemagazine.org/. *Hektoen International* is an online journal that explores the field of the medical humanities and maintains an online art gallery and library for archiving artwork and articles. See www.hektoeninternational.org/ *The Examined Life: A Literary Journal* is a journal published biannually by the Writing and Humanities Program at the Carver College of Medicine. *Bellevue Literary Review: a journal of humanity and human experience* is also an excellent resource for literary writing and curriculum guides on various topics including multiculturalism, aging, disability and infectious disease. For more information see http://blr.med.nyu.edu/.

[7] A note on terminology: People who provide care can be referred to as healthcare providers, service providers, practitioners, healthcare professionals or therapists. I have chosen to use these terms interchangeably. There is a wide range of terms used to designate people who receive care including patients, clients, service users, consumers and survivors (in some contexts). I have chosen to use "patients" and "clients" interchangeably depending on the context of the discussion.

[8] Accessed 27 March 2013: http://centerforhealthmediapolicy.com/2012/09/27/calling-all-nurse-writers.

[9] Accessed 27 March 2013 from www.gla.ac.uk/schools/critical/research/conferences/attentivewriters/.

anthropologist Cheryl Mattingly's (2010) suggestion that professions, as social categories, are best treated as "cultural resources that inform life on the ground, not as containers that enclose it" (47).

Not wanting to reproduce an omniscient writer's voice I have written myself into the dissertation in multiple ways. I start with a story from my own practice as a jumping off point – or anthropological 'arrival story' – signalling my presence in the text (Finlay, 2002) and providing a context for my discussion. I weave my own poetic accounts of practice as a direct response to other texts, as a way to make meaning of my practice experiences and to add my voice to the larger thesis narrative. My poetry is not an attempt at 'great poetry' (Richardson, 2010),[10] but rather is in keeping with my intention to situate myself explicitly in the inquiry and create openings for multi-layered and generative conversations about practice.[11]

My interest in collapsing the boundary between creative writing and scholarly inquiry is consistent with constructionist, arts-based and autoethnographic approaches which attempt to disrupt the binary between science and art. As Ellis, Adams and Bochner (2011) state, autoethnographers assert that research can be both theoretical, analytical *and* aesthetic – and inclusive of both personal and social phenomena.

> Autoethnographers also value the need to write and represent research in evocative, aesthetic ways... One can write in aesthetically compelling ways without citing fiction or being educated as a literary or performance scholar. The questions most important to autoethnographers are: who reads our work, how are they affected by it, and how does it keep a conversation going? (39)

Background notes

I have tried to maintain the integrity of the poems by presenting them in full (wherever feasible). In doing so I intend to position the practitioner/writers more as 'authors than

---

[10] For a fuller discussion of the tensions regarding 'quality' and 'qualifications' in arts-based inquiry see Piirto (2002). While I agree that issues of quality in arts-based research are important, I suggest that any understandings of 'good' art need to be considered within the context and purpose they are being used for (i.e., literary craft or knowledge building).

[11] In trying to honour confidentiality, I have relied on composites or 'thickly veiled' accounts, leaving out details of clients' circumstances as well as details on the clinical circumstances. For further discussion on the dilemmas involved in writing about clients, see Chapter 2, *(Re)visiting my story: reflecting on narrative*, in which I explore issues of voice and authorship.

subjects' (Davies, 2007) and encourage readers to engage directly with these texts – individually or as part of the larger narrative of this inquiry. For easier reference, the poems are listed by title in the Table of Contents with corresponding page numbers.

In acknowledging the dynamic relationship of form to content, I have tried to attend to the aesthetics of this document through the use of visual images. I agree with Belsey (2007) that it is a pity to isolate the visual from the textual, so I have incorporated photographs throughout the text to 'punctuate' the space between sections of writing, and create a multi-layered conversation of words and images (Gergen, 2009). Most of the images have been taken from digital storytelling projects involving healthcare providers. In doing so, I acknowledge the wide range of creative storytelling practices, and the evocative quality of images, to create multi-dimensional narratives of practice.

Inspired by Sacks' idea that writing about illness is like making "house calls at the far borders of human experience" (cited in Mattingly, 1998: 1), my thesis borrows heavily from the idea of writing from the *borders* of practice. I am most interested in those 'in-between' or 'liminal' places not visible in official accounts of practice, but spaces that can offer rich accounts of what it means to be a healthcare practitioner. I agree with healthcare anthropologist and occupational therapy professor Cheryl Mattingly that to "narrate one's experience is part of the very human need to be understood by others, to be in communication, *even if from the margins*" (1998: 1).

My philosophical stance is grounded in critical social science that takes seriously the "role of words, texts and their meanings" (Denzin and Lincoln, 2011). I view narratives as *discursive resources* (McNamee & Hosking, 2012: 35); while neither "right" or "wrong", they orient us to the world differently and are a valuable resource in promoting relational practice. While this approach offers "no guarantees", I remain hopeful that "critical qualitative inquiry, inspired by the sociological imagination, can make the world a better place" (Denzin and Lincoln, 2011: x).

In the next section, I introduce a story from my own practice. This is a way to both ground this inquiry in my own experience as a practitioner, as well as a means to explore the role of narrative in professional practice and narrative inquiry. My story leads to a fuller examination of concepts related to narrative inquiry, including narrative 'truth', issues related to 'voice', the ethics of writing about practice, and the emerging role of personal narrative and reflective narrative writing in professional and scholarly work.

2. (Re)visiting my story: reflecting on narrative

The narrative approach to inquiry has helped me to see that categories break down, and that we are all implicated in each other's stories.

Carmen Maggisano, 2008

I possess nothing but the everyday out of which I am never taken.

Martin Buber, 2002

Writing has so much to give, so much to teach, so many surprises.

Anne Lamott, 1994

Overview

In this chapter *(Re)visiting my story: reflecting on narrative*, I begin with the story 'How and Why We Speak: Reflecting on Loss and Connection', a personal narrative written about my own practice. This is a way to ground my interest in this topic as well as a way to explore more fully the role of narrative writing in inquiry and professional practice. Re-visiting and reflecting of this story leads me to a fuller examination of concepts related to narrative and narrative inquiry including notions of narrative 'truth', issues regarding voice in narrative writing, the ethics of writing about practice and the emerging role of personal narrative and reflective narrative writing in professional and scholarly work.

Following the reflections on my own story, I turn my attention to a fuller discussion of my conceptual and philosophical approach to this inquiry. Drawing largely from constructionist and relational frameworks, I discuss the relationship of knowledge to day-to-day practice, the importance of reflexivity in inquiry, and the role of narrative in creating possibilities for research on practice. Interested in the relational possibilities of narrative writing, I explore 'writing as a method of inquiry' and 'dialogical' approaches to narrative (including the concept of social poetics and relational poetry) which has allowed me to insert myself into the text in meaningful ways and extend the conversation(s).

I wrote the following piece, in collaboration with therapist and long time colleague Laura Anderson, about my relationship with a client. In 2007 the piece was published in *Reflections: A Journal of Professional Helping* whose mandate is to share powerful and intimate experiences in social work and other helping professions.[12] I include an excerpt from the piece here, as it was originally published, as a way to reflect on narrative in professional practice and as a springboard to consider issues in narrative inquiry.

[12] *Reflections*: *A Journal of Professional Helping* was first published in 1995 by California State University, School of Social Work and since 2012 has been published by Cleveland State University, School of Social Work.

Story: 'How and Why We Speak: Reflecting on loss and connection' (an excerpt)

Lorraine Hedtke writes in The Origami of Remembering of the importance of telling our 'relationship stories' – especially those stories that would otherwise go unnoticed. This is one of those stories. It is a personal account of my relationship with 'Angela'[13] – a client who taught me much about collaborative and respectful practices through her continual resistance to being made 'other'. This is also a story about coming to terms with loss, for three years ago, after struggling for many years with despair and other oppressions, Angela died of an overdose...

Despite my awareness of the depth of her distress and the often overwhelming nature of her problems, I experienced waves of shock, anger and sadness at the awful finality of her death. And in spite of my intellectual understanding that some problems are too large to overcome, I experienced pangs of doubt and regret – at conversations not had and missed opportunities for connection – as well as a vague sense of failure and hopelessness. I started to write about our connection in the hope of finding a way 'out' – a way to make sense of what had happened...

More than any theoretical analysis of postmodern practice, it was Angela who taught me most about noticing the often taken-for-granted practices which can disconnect us from the clients we work with. After years of journeying through the mental health system, she had a finely tuned understanding of the potentially disconnecting effects of clinical language as well as the role of language in shaping meaning. My education is treating clients as 'people rather than cases' (Winslade 1997) began almost immediately when Angela walked through the door of my counselling office and challenged the very idea of keeping a file on her. Refusing to be categorized and filed away, she stated simply but clearly, 'I am not a chart number'.

The issue of language surfaced in other ways as well as we struggled over the naming of our relationship. Over time Angela came to define/name our professional/therapeutic connection more as a friendship. While I remained uncomfortable with this label because of the blurring of personal/professional lines it implied, at some point Angela asserted her right to name our relationship and the meaning it held for her. She began to refer to me as her friend – and to her we were.

Towards the end of our relationship, worn down by years of mental health crises and at times seemingly overwhelming problems, I found myself going

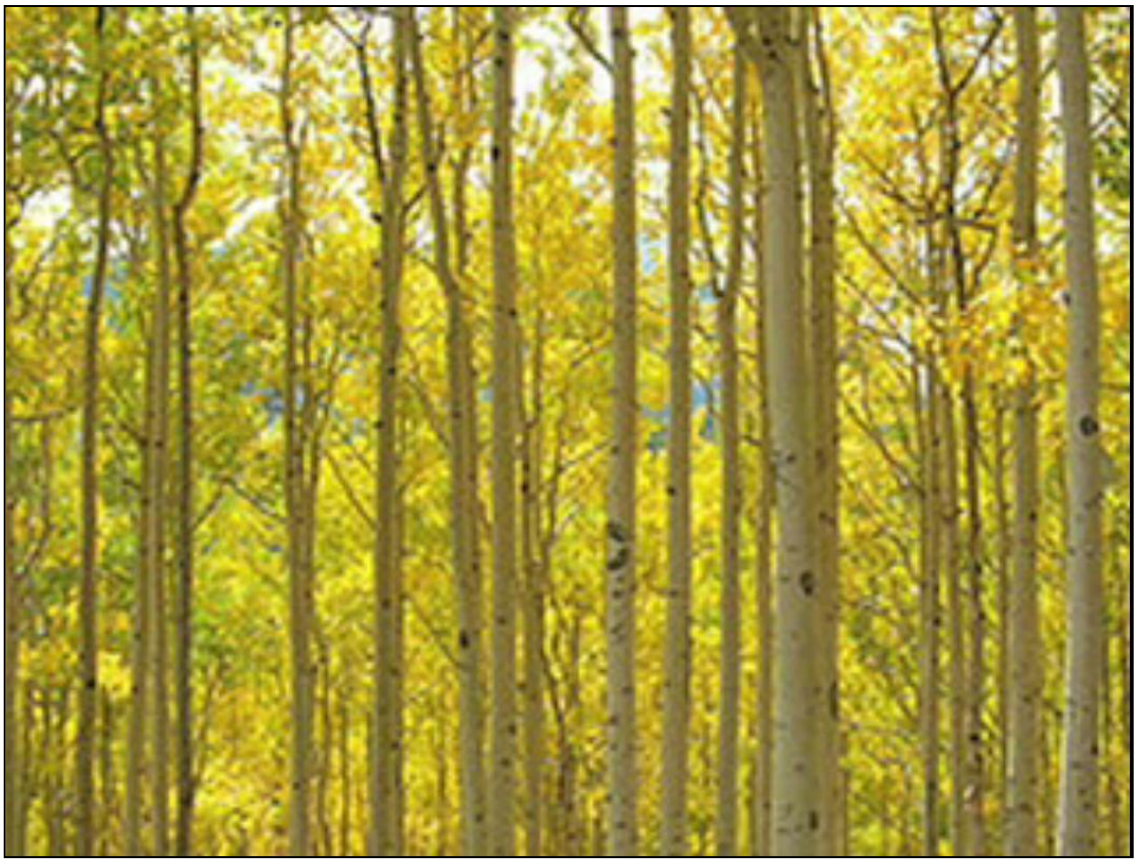
[13] I have changed the client's name and omitted details of her circumstances to respect her privacy.

increasingly to a place of not knowing and often not doing as well. I had moved towards trying to be with her and just say 'I don't know' or 'I'm not sure' when I really wasn't. It felt tentative, and at times not very useful, but somehow more honest. Witnessing was, at times, all I had to offer. After her death, I was similarly thrown into "not knowing" territory asking questions that were difficult, if not impossible, to answer: Why weren't the connections and support that Angela had so carefully cultivated over the years, along with her hard won survival skills, enough to sustain her? Did she deliberately end her life? And, given her long and at times intense struggles with suicidal thoughts and actions, does the answer really matter? Finally, and perhaps most critically, what more (or what else) could have been done to help?

...While it has felt important to express and honour the impact of my relationship with Angela, the writing of this piece has not been an easy task. At times revisiting the story of our relationship has helped me connect to moments of hopefulness, connection and strengths (both hers and my own); at other times it connects me only to the sadness of losing her. It is these memories and images, however, that help sustain in me the idea that people are not defined by their problems and oppressions – however real those are. I hope that the telling of this story does justice to our connections and to the transformative impact Angela has had on our work/lives – by giving voice to both what has been lost and what has been sustained.

Gold, K. with Anderson, L. 2007. "How and Why We Speak: reflecting on loss and connection. *Reflections: A Journal of Professional Helping*.

Thinking about narrative



Sometimes even beginnings require explanation. Where an event begins may be a matter of how we punctuate it, where we insert a capital letter or paragraph into time.

Howard Stein, 2007: 80

Narrative humility is the sense of humility toward that which we do not know – the face of the Other, the face we cannot know but to which we are responsible.

Craig Irvine[14]

[14] Cited in DasGupta, 2008: 980.

I include this excerpt from my personal narrative 'How and Why We Speak' for many reasons. First, it seems appropriate to start a narrative inquiry with a story as "in the beginning is a story – if only because the idea of a beginning presupposes a sense of narrative" (Frank, 2010: 20). I begin here as well because this story about my relationship with Angela invites us to think about the ways that we construct meaning from our practice through storytelling.

I share a story from my own experience to illustrate the role of personal narrative in challenging the rigid boundaries between the personal and the scholarly (Ellis 2009). I revisit a piece of my own writing – in a sense both *re-reading and re-writing* it (Denshire, 2010) as a way to explore certain theoretical concepts in narrative inquiry and the "echoes of other important works that shape my understanding of practice and inquiry" (Gergen, 2009: xvii).

I start with a personal story because I agree that in writing about other people's lives, our own lives and unique positionality, are inevitably implicated. Sikes (2010) suggests that it is unethical to write about others (or social phenomenon) without acknowledging one's own position or "making clear the nature of the gaze that is being brought to bear" (13) by articulating our interest in a particular topic, how it relates to our experiences, and what theoretical perspectives we are bringing (19). Speaking about the importance of reflective processes in narrative inquiry, Maggisano (2008) suggests that "understanding and accepting others begins with the understanding and acceptance of self" (12).

Explicitly acknowledging one's personal location stands in contrast to what Jane Speedy (2002) calls 'writing from nowhere' – the tradition of an anonymous "God's eye" perspective that goes unchallenged in conventional academic writing. Not interested in "leaving myself out of the picture" through an invisible and omniscient narrative voice (Tierney, 1998: 24), I have attempted to position myself explicitly in the text I am producing (Speedy, 2002: 68). Not wanting to "hide" in my writing (Tierney, 1998), "I have tried to remember who I am, and even who I once was" (Mattingly, 1998: vii) and have chosen to write in a voice of "direct address – speaking to *you* rather than writing of *them*, and of *us* rather than *one"* (Frank, 2004: 10).

Personal narrative, like my piece "How and Why We Speak" can be seen as a form of "evocative and analytic auto-ethnography" that seeks to re-inscribe the everyday world of practice that is often "written out" or missing from mainstream accounts of practice (Denshire, 2010). As social worker and writer Rita Wilder Craig (2007) points out in her article on the role of personal narrative in professional practice, the humanities assist us in dealing with the often neglected 'absurdities encountered in everyday social work practice'. Wilder-Craig suggests that personal narrative can counter the 'chasm of silence' in social work scholarship (434) by providing insight into the realities of day-to-day practice and the practice-based knowledge of practitioners.

In their exploration of healthcare interactions, Katz and Shotter (1996) similarly focus on "often ignored moments" in clinical interactions suggesting that a relational, dialogical approach privileges ordinary language and "draws our attention to events that might otherwise escape our notice" (919). A poetic-relational approach draws our attention to such "fleeting but 'moving' moments" and provides opportunities for new connections and conversations as clinical talk is viewed as an interactive and embodied process. Informed by Wittgenstein's interest in poetic images and a focus on the 'particular and the practical', this approach leads us towards the indeterminate and 'directs our attention to new possibilities and practices' (Katz & Shotter, 1996: 926).

I have chosen narrative writing (in the forms of poems, short stories and personal narrative) as the focus of this thesis as a way to make visible everyday knowledge about practice and neglected aspects of lived experience (Denshire, 2010; Elizabeth, 2008). Occupational therapy professor Sally Denshire (2010) draws on de Certeau's notion of the 'immense remainder of human experience' to point our attention to the "under-life" of healthcare practice as "every working life will have a number of subjugated places, an 'immense remainder' of human experience that 'does not speak'" (529).

Discussing the importance of making visible 'otherwise marginalized knowledge,' Denshire draws attention to not only what is missing from mainstream accounts of practice, but the importance of documenting such 'ordinary everyday moments'. While acknowledging that "these everyday processes are often overlooked as 'under the radar'", she points out that these experiences are often "relegated with no pause for reflection to the 'back rooms and corridors' of our working lives":

> Practitioners may reflect on, and perhaps talk about, ordinary everyday moments of practice but rarely have an opportunity to write them publicly. The subjugated knowledges in our working lives are part of the 'immense remainder' of human experience that 'does not speak'. By writing about the spaces of everyday life... de Certeau elevates these subjugated places and their occupants 'articulating a discourse on non discursive practices (Denshire, 2010: 529).

The writing of my essay, 'How and Why We Speak', was an attempt 'to cut through the inarticulate secrecy and silences we all carry' (Ellis, 2009: 188) reinforcing Frank's point that stories make silences significant (2010: 107). It was a way to find the "art in practical stories... the stories people told in their lives and especially in their work" (Mattingly, 1998: ix); and in particular, a way to explore the impact of what social work theorist Catherine Phillips calls the "profound moments of loss and grief in our clinical practice that have left a lasting imprint on our work" (2007: 448).

Stories as a way of knowing

The term narrative has many meanings and is taken up in diverse ways by different disciplines as well as occupying different theoretical approaches within qualitative inquiry (Reissman & Speedy, 2007). While there is a wide range of theoretical principles underlying narrative analysis (Sparkes, 2007), narrative scholars generally agree on narrative as a central organizing metaphor, or way of understanding and/or constructing experience (Frank, 2010; Charon, 2007; Mattingly, 1998; Greenlaugh, 2001). Narrative forms of inquiry have been heavily informed by the 'linguistic turn' in social sciences (Ellis, 2009) and have been shaped by multiple theoretical influences including autobiographical theory, phenomenology, as well as arts-based and aesthetic approaches to research (Charon, 2007).

While understandings of narrative inquiry cover diverse theoretical territory, I am drawn to the description offered by Sheila Trahar (2009) that narrative inquiry acknowledges the importance of 'story' as a central construct, involves the gathering (or constructing) of some kind of narratives (visual, oral, written) and focuses on the 'meanings people ascribe to their experience'. As a practitioner researcher, or 'member of the landscape', (Clandinin & Connelly, 2000: 63), I have turned to narrative as a mode of inquiry and stories as a 'way of knowing' (Bruner, 1986).

Part of an emerging interest in narrative across a range of disciplines, this approach is closely tied to the blurring of boundaries between the social sciences and humanities as well as the blurring of lines between the personal, the professional and the scholarly. In their discussion of auto-ethnography, which they describe as a method of research and writing that lies somewhere between autobiography and ethnography, Ellis, Adams & Bochner (2011) state:

> Gradually, scholars across a wide spectrum of disciplines began to consider what social sciences would become if they were closer to literature than to physics, if they proffered stories rather than theories, and if they were self consciously value-centered rather than pretending to be value free... In particular, [these scholars] wanted to concentrate on ways of producing meaningful, accessible and evocative research grounded in personal experience (Art 10).

Narrative inquiry does not attempt to provide a picture of what is happening through large scale studies, nor is its value in generating abstract generalizations (Mattingly, 1998). While positivist inquiry looks to the study of the particular as a foundation for constructing broader knowledge claims, narrative inquiry is interested in singularity – and the 'particulars of person and context' (Engel, 2008). In contrast to approaches that emphasize

detached observation, abstraction and 'generalizable conclusions', narrative approaches privilege specificity and local understandings.

Social work professor Ann Hartman (2000) writes about the role of "speaking very specifically about individuals in particular situations" (Maggisano, 2008: 28) in creating practice knowledge.

> It is really not so complicated; we must ask people and then listen. And as we listen, we must attend to different, to particularity, the contradictory, the paradoxical. As we do this, we will attend to that which may be quantifiably insignificant but whose presence may question a more conventional interpretation and expand understanding. Epidemiological studies are useful and important, but direct practice must be built on local knowledge, on the particular, on attention to difference and, most vital, on multiple voices (22).

Attempting to honour both complexity and particularity, narrative inquiry encourages us to 'step back' and question the very construction of narrative itself; asking 'who constructed the story', 'why', 'in what context?' and 'what cultural discourses does this story draw upon?' In answering the question 'what is narrative inquiry?' Trahar (2009) states, "narrative inquiry is based firmly in the premise that, as human beings, we come to understand and give meaning to our lives through story... narrative inquiry is more than the uncritical gathering of stories [as it] strives to attend to the ways in which a story is constructed, for whom and why, as well as the cultural discourses that it draws upon" (Art 30).

In reflecting on the theoretical conversations that have shaped her practice, collaborative practitioner and theorist Harlene Anderson comments on narrative as a central organizing discourse and a crucial aspect of constructionist approaches. Arguing that narrative is more than a "storytelling metaphor", Anderson uses narrative not as a template for predicting behaviour, but as a metaphor for a process.

> Narrative is a form of discourse, the discursive way in which we organize, account for, give meaning, understand, and provide structure and coherence to the circumstances, events, and experiences in our lives... narrative is a metaphor for a process; it is not a template or map for understanding, interpreting, or predicting human behavior... As Gergen (1994) suggests, 'stories serve as communal resources that people use in ongoing relationships' (Anderson, 2007b: 16).

In reflecting on my own practice narrative I am keenly aware of some of the dilemmas surrounding the use of narrative in scholarly and professional writing – in particular, the difficulties in attempting to 'represent' the 'other'. While narrative reflections may open up

the possibility of richer accounts of practice, we need to be mindful of the incomplete and partial perspective of *all* stories. In thinking about Brett Smith's reminder that ethical reflexivity involves not 'violating the alterity (or otherness) of the other', I am reminded that there are *at least* two narratives 'intersecting in complicated ways' in any encounter – the practitioners' and the patients/clients' (Hogarth & Marks, 1998: 144).

Exploring the interconnection of narratives in clinical settings, Frank suggests that by giving voice to someone else's story, we are indirectly giving voice to our own as 'illness narrative gives birth to caring narrative while caring narrative gives birth to illness narrative' (in DasGupta & Hurst, 2007: 270). In this sense, in telling a patient or client's story we are also telling our own. This blurring of our own stories with the stories of others is what Carl Leggo (2010) may be hinting at when he says, "When I tell a story, I know I am really telling my story, even when the story is significantly about somebody else" (71).

Thinking about Ellis' (2008) caution to not get trapped or stuck in our own stories, how do we acknowledge that our personal histories can be 'prisons that lock us in and limit our horizons of knowing'? (Britzman in Connelly & Clandinin, 1994: 151). Trahar also points out that one of the dangers of personal narrative is the privileging of our own stories – by pushing "other" voices to the margins. In discussing the dilemmas of practitioners who write about their own practice, Anne Kinsella recognizes the danger of "freezing these accounts of practice as true and unintentionally obscuring client perspectives by privileging our own'"' (Kinsella, 2005: 69).

In examining ethical dilemmas related to the 'ownership' of practice-based stories and the role of narrative in the encounter with the 'other before us', narrative medicine scholar Sayantani DasGupta calls for narrative humility. She reminds us that while clients' stories may intersect with our own in powerful and meaningful ways, the stories of our clients/patients are never completely our own – nor are they merely objects of our investigation:

> [O]ur patients' stories are not objects that we can comprehend or master, but rather dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction, and engaging in constant self evaluation and self critique about issues such as our own role in the story, our expectations of the story, our responsibilities to the story; and our identification with the story... (DasGupta, 2008: 981)

In considering the dilemmas of narrative inquiry – whose story is being told (and made) here? who is doing the telling? who has the authority to make their telling stick?[15] – I

[15] Denzin, 1997: 180.

am aware that by writing about my relationship with Angela, I may be unintentionally obscuring her story. I also know that I hold the power to tell this story and Angela will not be able to write hers story – or contribute to a collaborative account of our relationship.

While in some sense my piece remains largely monological (i.e., in one voice), it was written with her words, and fragments of our conversations still ringing in my head. Her quiet sense of defiance against objectifying professional practices, and her keen sense of language, were constant companions as I wrote this piece (and as I re-visit it here). Even after many years, the article feels like part of an ongoing conversation; writing about her now feels like another chapter in an ongoing (now internal) conversation. And while this story was told ultimately from my perspective in my voice, I nevertheless feel some responsibility to tell it.

In taking seriously DasGupta's (2011) advice about the ethical obligations of the witness, I am reminded to pay attention to questions like: What do stories do to us?' What is our responsibility to them? To whom do stories belong? What is the role of a witness? (16). Ultimately, I agree with Frank (2004) that the issue of ownership – or whose story is it? – becomes complicated as stories serve their tellers and listeners in different ways. As he says "the story seems to be no one's *own*; it exists amid of these relationships, which the story itself works to shape" (210).

While narrative inquiry and autoethnography may carry the risk of centering our own lives as researchers/writers, I remain drawn to it as a method for investigating practice as it acknowledges the researcher's presence in the work and the research process itself as a meaning-making journey. By 'privileging' narrative perspectives, I recognize that "I, too, lead a storied life and the research relationship is part of my experiential text" (cited in Trahar, 2009: par 8). While this may detract, at times, from the storied lives of others (Trahar, 2009), I choose a narrative approach it focuses on investigating the meanings of experiences and, at the same time, views the research process itself as a series of experiences (Trahar, 2009).

Reflexivity and ethics in personal narrative

As a way to make meaning out of a difficult experience, the writing of 'How and Why We Speak' provided a way to be audience to myself, which raises issues of *reflexivity* in our work. Being self reflexive requires holding dual and alternating perspectives as both a writer and a reader. Poet Billy Collins describes this process as:

> as soon as I start to write I'm very aware, I'm trying to be aware that a reader just might well pick up this poem... and if there's something interesting going on there, then I'll go forward, turn back into the writer, and write another two or three or six lines, and then go back and bring the reader out.[16]

Reflexivity also implies that the writer/researcher must "examine carefully what she brings to and contributes to the process... narrative inquirers do not shy away from tensions that occur in their work. Instead they always honor the personal and local and participate in the continuous stream of experience... for co-constructing understanding..." (Butler-Kisber, 2010: 66). As education researcher Lorri Neilsen suggests, narrative research calls into question conventional assumptions about knowledge and professional knowing:

> We make our way in the world – whether we are carpenters or researchers – according to the stories we tell each other. We could call them illusions. And in the academic world we call the discussions of these stories theoretical debates... Researchers whose work is informed by the arts... work with ideas that cannot easily be fixed, determined... Knowing is a fiction, and fiction is a form of knowing (Neilsen, 2004: 45).

It challenges hard divisions between (so called) objective and subjective knowledge, reminding us that writing is not about a search for Truth or an attempt to represent a factual account of 'what really happened'. Rather, narrative is an attempt to construct a story that 'makes sense' – or a story that one can more easily live with. 'If the border is fuzzy between life and narrative', Booth writes, 'the distinction between narratives that are true and those that are fiction is even fuzzier' (cited in Frank, 2010: 16).

Nurse/writer Sandra Bishop Ebner, writing in an anthology of nursing poetry, acknowledges the tensions of writing about our work asking, "how does one write about one's work when one has the moral and legal obligation to keep the conditions and experiences of patients confidential? The 'facts' need to be 'fictionalized', which, in actuality, is often true in most poems or words of art when imagination goes to work" (in Schaeffer, 2006: 59). Blurring the line between 'fact' and 'fiction' (or fictionalizing actual accounts) is a useful way to navigate ethical questions about the ownership of narratives and concerns around privacy of both practitioners and patients/clients.

Issues of 'validity' and 'accuracy' in inquiry reflect assumptions about 'neutrality' and 'objectivity' which do not fit a constructionist understanding that the "world is constructed in and through our discourse and actions" (Butler-Kisber, 2010: 78). In avoiding the 'realist

---

[16] From an interview in Guernica Magazine. Accessed 27 March 2013 www.poets.org/viewmedia.php/prmMID/19796.

tales' of early anthropology and social science (Finlay, 2002), I am intrigued by Shklovsky's metaphor of stories as "sketched windows" in which the viewer is not attempting to look through the window to something beyond or presume that the sketch accurately 'represents' what lies beyond. Rather, "the sketch itself is well worth looking at" (Frank, 2010: 89).

Calling into question the distinction between 'real data' and fiction (Frank, 2010), Lynn Butler-Kisber (2010) suggests that ethical practices in inquiry have more to do with the relational issues at hand including, the stance and positioning of the researcher:

> The boundaries of fact and fiction blur when we think of the constructed nature of narratives. In fact, some narrative researchers turn to fiction in the most traditional sense to work through different ideas emerging from the work, to write more autobiographically, and/or to reach broader audiences. Of more concern is the observance of ethical practices throughout the research process that attend to the relational nature of the work, the positioning of the researcher in the inquiry, and that focus on issues of power and voice (78).

Focusing on the way that narrative themselves are created, educational researcher Maggisano (2008) states, "Since stories are not objectively given, but instead are *constructed* [my emphasis], they have intentionality because stories are chosen to be told. The ordering of details is a construction and the conclusion or 'moral' of the story is an interpretation"(9). Attempts to *story* my own experiences have reinforced the notion that we continually construct experience, not reproduce 'what really happened'.

This is what author Tim O'Brien refers to as the difference between 'story truth' and 'happening truth'. As Donald Spence (1982) comments about the relationship between narrative truth and historical truth, "narrative truth has a special significance in its own right and that making contact with the actual past may be of far less significance than creating a coherent and consistent account of a particular set of events... once a given construction has acquired narrative truth, it becomes just as real as any other kind of truth" (28-31).

In her discussion of personal narratives in scholarly work, Carolyn Ellis encourages us to shift focus from facts and representation to 'evocation' (Ellis in Tierney & Lincoln, 1997) so that scholarly writing feels more like an "intimate conversation about the intricacies of feeling, relating and working" (127). In commenting on the writing of her autobiographical account of illness and her relationship with her husband she writes:

> As I wrote and rewrote, I moved closer to telling an evocative and dramatic story and farther away from trying to get all the ethnographic details 'right'... more and more I moved away from trying to make my tale a mirror representation of chronically ordered events and toward telling a story, where the events and feelings cohered, where questions of meaning and interpretation

> were emphasized, and where readers could grasp the main points and feel some of what I felt. (Ellis, 1997, 128)

If "we must assume an audience for our work"(Cahnman, 2003: 35), I am given pause to think more deeply about the notion of "audience" in my own writing. As Gergen and Gergen (2002) point out, the relationship between researcher and audience is often a neglected aspect of ethnographic writing. In considering issues of 'voice' in our writing, we are asked to contemplate the question 'to whom do we speak?'. Our (imagined) audiences influence the voice(s) we choose for ourselves as researchers/authors (Lincoln, 1997: 45) and we often speak in two voices, as both the 'subject' and 'author' of the tale. Carolyn Ellis (2008: 13) writes,

> I am both the author and the focus of the story, the one which tells and the one who experiences, the observer and the observed, the creator and the created. I am the person at the intersection of the personal and the cultural...

The issue of 'audience' raises issues related to the making of personal, or private, stories public. I would agree that as practitioner/researchers/writers, we need to write from a 'threshold of vulnerability' (Osipov, 2011). In other words, an ethics of writing involves reflexively positioning oneself in the writing. Being 'vulnerable' in this sense means turning the gaze not only on others, but on ourselves. I agree with sociologist Vickers (2002) that researchers who share their own experiences "expose themselves in no small way" by challenging established dualisms between the personal and professional or the personal and scholarly. Vickers, who has written publicly about her own struggles with depression and chronic illness, emphasizes the close connection between personal history and scholarly work – while at the same time acknowledging its potential dangers (Vickers, 2002: 619).

Urging us to reclaim the marginalized role of the researcher as storyteller, Vickers likens the dangers of writing personal narrative to *writing without a safety net*. "What remains for researchers who choose to tell their stories is to know that they truly are writing on the edge – and there is no safety net". In thinking about the riskiness of 'constructing ourselves on paper'[17] Vivienne Elizabeth states, "for one thing, writing fixes words – and, hence,

---

[17] Writer and medical educator Kwame Dawes comments that personal narrative involves "putting ourselves out there". Reflecting on his teaching of medical students, he is struck by the "cautiousness" of their writing which he attributes to their "training in avoiding anything exposing or vulnerable", and the "obscuring of the self to create distance and anonymity". This, he suggests, is part of their emerging professional identities as physicians. While not claiming that writing needs to be overly confessional in nature, he suggests that "writing should reveal us in some way as it is the personal voice which provides the urgency needed to impact on others". See *Vulnerability* in Kwame Dawes blog, posted 13 April 2011 in www.poetryfoundation.org.

constructions of selves and others – on paper. Thus, the stories we record in writing may be harder to undo than the stories we commit to speech. After all, words spoken in the absence of some means of recording are subject to the vagaries of recall, whereas words written down can be re-materialized..." (Elizabeth, 2008: par 21). In a conversation on autoethnographic writing, Shelley Green explores the impact of making personal narratives public stating,

> if you announce it to other people, it becomes a different kind of story, and then you have to deal with your relationship with it in relationship with the audience... you have to decide if you're ready to be outed or to put yourself out in that way. You have to think about what that will do to your professional identity and your personal relationships (Flemons and Green, 2002: 166).

Green's words resonate as I recall my ambivalence at being public about my relationship with Angela and the airing my own doubts, uncertainties and vulnerabilities.[18] I was aware while writing the 2007 article that I was breaking both 'process and content taboos' (Vickers, 2002) as the piece moved away from conventional academic and professional writing towards that of personal storytelling. Thinking about my potential audience(s) of students, clinicians and educators, I was keenly aware that some readers might feel that I transgressed professional boundaries in my relationship with Angela – as well as crossing certain boundaries in going 'public' with the story through publishing the essay in a professional journal.

In her discussion on the "heavy ethical burden" of writing about others' lives, educational researcher Pat Sikes (2010) reminds us that writing about others is always implicitly tied to writing about ourselves and that all auto/biographical writing implicates others. In telling our own stories, we are implicitly telling about others. While the boundary between writing about self and other may be blurred, it is nonetheless important to think about issues of *narrative privilege* (who gets to write the story), and to take seriously our responsibility to consider carefully what stories we tell and how we re-present them.

While I agree with Sikes (2010) that 'there are no easy answers', questions such as 'have I been respectful in my telling with the language I have used?' has been a useful way to navigate ethical concerns around my own writing as I weighed carefully the words used to describe my relationship with Angela and how they might be construed.

---

[18] I use the term 'being public' (rather than transparent) defined by Harlene Anderson as "the reflecting and sharing of one's work – more readily sharing out loud my private inner dialogues and monologues: my thoughts, prejudices, wonderings, speculations, questions, opinions and fears... consequently I expose myself more as a person to all those with whom I work. I choose to use the word *public*... as we can see only what we each choose to show the other" (Anderson, 1997: 102).

While embracing a more 'modest professional identity' (Winslade, 2002) and acknowledging doubts and uncertainties fit well for me, I was concerned about how my piece would be 'read' within a largely expert-driven professional community. If the way we re-construct experience is intimately tied to the construction of identity (Schwind & Lindsay, 2008: xiii), then I worried about how the telling of this story would affect how others saw me. I agree with Maggisano (2008) that the stories we choose to tell continually shape our identity "either breaking or reinforcing the 'self' others have shaped for us" (9). And as stories construct our identities, so too are stories themselves construction.

Despite the riskiness of personal narrative in professional contexts, I remind myself that readers respond, and 'take up', stories in many different ways. I try to be mindful of the questions, "how is the audience invited into the story and where do they live in that story?" (Flemons & Green, 2002: 166) which acknowledges that readers have their own responses – shaped by their own experiences and perspectives. This validates the interpretive 'openness' of any text, as I would agree with Mairs that my "text is flawed not when it is ambiguous or even contradictory, but only when it leaves you no room for stories of your own. I keep my tale as wide open as I can…"(cited in Ellis,1997: 132).

As a reminder of the dynamic and open-ended process of storytelling, my ambivalent feelings about making my story public were tempered somewhat when I learned of two Master of Social Work students who have used the story about Angela to facilitate their own reflections on the relationship between personal history and professional identity. In the theses 'A Personal Narrative: Journey through an Unplanned Pregnancy, the Welfare System and the Pursuit of Higher Education' by Susan Parker (2009) and 'Biracial Identity Development: Understanding a Sense of Self' by Ghislaine DeBong (2009), both authors use my story as a resource for understanding how their own experiences and social/cultural identities shape their emerging professional identity as social workers.

In acknowledging that autobiographical 'lifewriting' is fraught with risks and tensions, it is important to recognize that there are dangers in *avoiding* such writing as well as many things remain silenced. And while I can choose not to tell my stories, I am still 'immersed in my stories' (Leggo, 2010). While acknowledging the ethical complexities of personal narrative, it is still important to tell them as there is value in the telling of even 'faulty accounts' (Campo: 2011). As Carolyn Ellis writes, "experience cannot be captured fully; once it happens, it can only be interpreted from limited and partial perspectives. Nevertheless, it is important to be able to story ourselves, to have a story to tell, and to tell it as well as we can" (Ellis, 2009, 14).

The writing of my story confirmed for me the importance of narrative as a neglected, but important, form of knowledge in professional practice. Challenging the hard distinction between the personal and the professional, personal narrative resides somewhere at the

"edge" of dominant practice paradigms. Social work professor Anne Weick (1999) refers to the 'humble stuff of lived experience' evocatively as "dangerous or guilty knowledge" as it calls on us to challenge assumptions about what we value and what (we think) we know:

> to claim that social work knowledge is formed from the humble stuff of lived experience and values flies in the face of most current views about how social workers know what they know. In the tradition of the last fifty years in social work, the trend has been toward seeking knowledge gained at a distance. We have learned not to trust our eyes... but guilty knowledge is dangerous knowledge. It is knowledge that sits at the edge of the dominant knowledge paradigm persistently challenging the assumptions about the value of what we know (Weick, 1999: 329).

Challenging the idea that our own experiences are 'too personal' or 'too subjective', writer and cultural anthropologist Barbara Myerhoff also called attention to how the widespread use of the third person voice was part of the prevailing positivist philosophies of science. Interested in the 'first person' voice in social science research, Myerhoff (1992) encouraged social scientists to challenge assumptions about 'objectivity' and 'detachment' in their writing.

> Narratives, particularly in the first person, are considered by most anthropologists and social science writers to be too personal and too subjective to be vehicles for specific communication... Scientists are supposed to use the passive voice and the third person... Both literary devices cause statements to appear to be authorless, authoritarian, objective, and hence in keeping with the prevailing positivist/empiricist philosophies of science (1992: 322-328).

Revisiting my piece about Angela brings to light the dynamic movement of stories long after they are written; in other words that the meaning of a narrative is not static as it unfolds over time as we 'continue to interpret, question, and reinterpret what happened then from our position now' (Ellis, 2009, 140). This understanding of meaning as something that is continually evolving and changing is suggested by Johnston's (2007) notion of '*the twilight zone between the meaning that has been and the meaning yet to arrive*' (115).

In this sense, the lens through which I view my article is different now than when it was originally written and published in 2007, shaped by my experiences of the last five years as well as by the experience of writing and publishing the piece that, as Ellis (2008) points out, impacts and alters the meaning of the story itself. In this 'twilight zone of meaning' I am continually making sense of my stories; far from a static or fixed document, my relationship to the story I created in 'How and Why We Speak' continues to evolve.

The writing and telling of 'How and Why We Speak' also helped me consolidate my preferred identity as a reflective practitioner – an identity that has served me well through many years of practice in the complex and sometimes 'perilous' landscape (Finlay, 2002) of practice. Identifying as a reflective practitioner has led me to seek out resources (like narrative writing) to assist me in making sense of the journey – particularly in the aftermath of Angela's death. I am reminded here of Brookfield's (2008) point that critical reflection is often triggered by traumatic events that cause us to question the rules of the dominant ideology and our own unexamined assumptions.

The topic of 'reflection' and 'reflexivity' in professional practice has been the subject of much discussion across many fields (Sheppard et al, 2000; Schmidt and Adkins, 2012;) and I cannot do justice here to the conceptual complexity of this area. For the purpose of our discussion I will use Davies' (2007) definition where she states that 'reflexivity', broadly defined, means a *turning back on oneself* in a process of self examination and analysis. While reflection may be an ill defined and multi-faceted concept, healthcare educators assert that it is an essential component of being a healthcare practitioner as it entails 'thoughtful and meaningful action in practice' (Kinsella, 2001: 196). In a discussion on the role of practice knowledge in the helping professions, Kinsella and Pitman (2012) assert that reflection is central to a professional identity grounded in an ethical and relational approach to care.

Arthur Frank (2012) writes that reflection is key for healthcare providers as it challenges taken-for-granted practices through an 'interruption' in the flow of otherwise 'routinised' experiences (5). In other words, reflection occurs in that 'carved out space' in which we stop and ask ourselves '*what are we doing?'* Social work professor Donna Wang (2012) also advocates the importance of a reflective stance that involves the ability to 'step back' and identify the larger discourses that affect our practice, thus allowing for a more intentional 'use of self' and the opportunity to depart from the *everydayness* of practice.

Other authors suggest that reflection is critical to respond to the 'absence of certainty', complexity and ambiguity characterizing day-to-day practice (Kinsella and Pitman, 2012: 5). Joy Higgs (2012) suggests that the unpredictability of professional practice requires an ability to 'blend art, science, craft and humanity' with ethical and collaborative sensibilities and multiple ways of knowing.

These understandings of professional practice strongly echo Donald Schon's influential theories of reflective practice developed in the 1980s. Schon called attention to the limits of positivist paradigms (and what he referred to as 'technical rationality') for understanding professional practice, preferring to conceptualize practice as a 'swampy zone' characterized by complexity and 'ill defined problems'. Schon challenged conventional assumptions underlying the normative curricula in professional training that emphasized basic scientific

knowledge as the basis for competent professional practice and reproduced problematic assumptions about the hierarchy of knowledge.

He was particularly concerned about the privileging of 'propositional or scientific knowledge' as the base for professional practice and the limitations of abstract knowledge for day-to-day practice (Schon, 1987: 9). Rather than relying on the 'high ground' of theory, Schon suggested that practitioners approach practice as a kind of 'indeterminate zone' requiring ongoing reflection and 'improvisation'. In this complex topography of practice, he suggested that research-based theory alone could not sufficiently address the 'messy confusing problems' of everyday practice. In *Educating the Reflective Practitioner*, he stated,

> In the swampy lowland, messy, confusing problems defy technical solution... These indeterminate zones of practice – uncertainty, uniqueness and value conflict – escape the canons of technical rationality... It is just these indeterminate zones of practice, however, that practitioners and critical observers of the professions have come to see with increasing clarity over the past two decades as central to professional practice (Schon, 1987: 3-6).

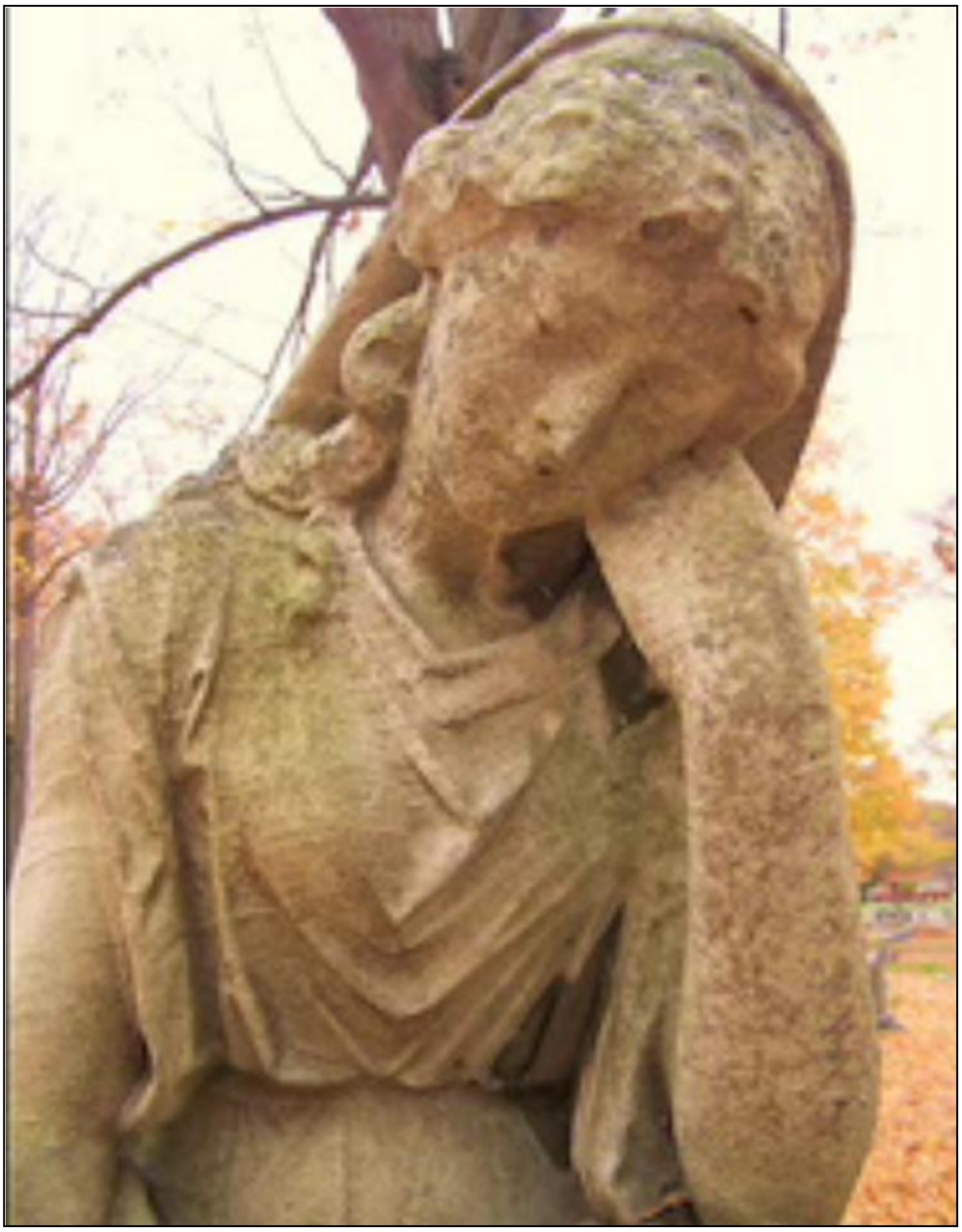
Schon thus played a pivotal role in conceptualizing practice as more than the application of 'technical solutions' – and competent practitioners as 'more than mere technicians' (Kinsella and Pitman, 2012: 118). Viewing "artistry" as an essential element of practice, Schon honoured the implicit or tacit knowledge that practitioners developed through reflecting on their practice. The notion of practice as an 'indeterminate zone' and a 'swampy lowland' remains an evocative (and I think useful) way of understanding the texture of day-to-day practice, and provides an alternative discourse to the over reliance on 'scientific' approaches.

In thinking about my attempts to construct a coherent narrative about my relationship with Angela, it strikes me that Schon's theories of professional practice make visible the very complexities of practice that I was/am trying to make sense of. While I agree with Tamas (2009) that writing about the messiness of trauma and loss does not necessarily fit into the "tidy reasonable voice" of autoethnography, it was the writing of 'How and Why We Speak' that helped me navigate the murky ground of our unconventional relationship, our imperfect attempts at negotiating a collaborative relationship and the 'indeterminate' territory of loss. As Cheryl Mattingly (2010) has rightly observed, "Life on the ground – that is, at the level of events – is inevitably messier" (56).

Understanding practice in this way has inspired me to seek out the narrative writing of other practitioners – to see how they make sense of the 'everydayness' of their own practice through personal narrative, short stories and poetry. I agree with Carl Leggo (2010) that narrative is an effective way to focus on the 'possibilities of meaning that lie always in the seemingly tangled messiness of lived experience'.

I turn now from my discussion of narrative to an exploration of concepts drawn from constructionist and relational theories to further develop my framework for inquiry. In particular, I explore ideas related to taken-for-granted assumptions, language as a social practice, and how dialogical approaches can provide an opening for new and generative conversations.

3. A frame for inquiry: a constructionist and relational methodology



If relational realities arise out of relational engagement (conversations, performances, dialogues), then we must pause and reflect, we must ask in what other ways we might talk about or perform this topic, this issue, this problem. We do not have to inquire or what as if the world is, or should be, just one way. Rather, our inquiries could open up new possible ways of being human.

McNamee and Hosking, 2012

Overview

Building on concepts from narrative inquiry discussed in the previous section, I further develop a framework for inquiry drawing on relational and constructionist approaches. For the purpose of my discussion, I highlight certain principles including the critique of individualist ideas about knowledge and identity and the emphasis on collaborative meaning-making. I draw heavily from the social constructionist metaphor of 'inquiry as conversation' and the idea that knowledge can be generated out of everyday practice. I also discuss the importance of a self reflexive stance, critical examination of taken-for-granted practices and the role of language in creating meaning.

In creating a dialogical approach to examining narratives by healthcare practitioners, I draw on three central concepts or approaches. I examine the idea of 'writing as a method of inquiry' which highlights the role of writing in constructing meaning, the concept of social poetics which emphasizes the notions of resonance and reverberation, and the idea of relational poetry which represents a form of dialogue through poetry. These interwoven concepts comprise the basis for my approach to inquiry as I arrange the texts in a meaningful way, analyze the writings in relation to the themes identified in the next section, and respond in poetic form to other texts.

Relational and constructionist inquiry: key principles

The philosophical orientation of my inquiry has been shaped by constructionist and relational approaches. I use the term constructionist here as a way to signal a certain philosophical stance towards inquiry (not as a particular method of inquiry), with a focus on how we create meaning together. This is based on the "assumption that language, seen as our embodied activities with each other, creates the ways in which we come to know and talk about our worlds" (McNamee, 2004: 226).

Dominant cultural (and language) practices tend to emphasize meaning as private or 'locked away' inside the individual (McNamee, 2007) and give limited attention to *coordinated* and *negotiated* efforts to generate knowledge (Gergen 1999). Writing about the idea of 'relational beings', Gergen states that "surely the conception of relational being reduces the debilitating gap between self and other, the sense of oneself as alone and the other as alien and untrustworthy. Whatever we are, from the present standpoint, is either directly or indirectly with others" (1999: 137).

Constructionist approaches are informed by relational perspectives on meaning-making and emphasize the collaborative metaphors of joint action, performance and the relational nature of constructed realities (Misra and Prakash, 2012: 122). Constructionist approaches suggest that:

> meaning emerges in the joint activities of persons in relation. To talk of meaning as relational requires that we replace our emphasis on individuals and their internal motivations, intentions, and perceptions with an emphasis on the "coordinated" activities of people engaging with one another (McNamee, 2007: 318).

As Shotter points out, this implies that we are constantly in motion and living in the midst of continuous change that leads us inevitably towards a more collaborative approach to inquiry (Misra and Pikrash, 2012). Within this dynamic view of inquiry, research itself can be viewed as a form of ongoing conversation (McNamee, 2000) and knowledge itself as a social practice (Anderson, AI, 86; Gergen, 2001; McNamee and Gergen, 1999; Anderson; Shotter).

Harlene Anderson (2003) writes about shared inquiry as a mutual process and conversational practice "in which participants are in a fluid mode and is characterized by people talking *with* each other as they seek understanding and generate meanings; it is an in-there-together, two-way, give-and-take, back-and-forth exchange" (149). Rather than viewing knowledge as something objective 'out there' to be found or discovered, meanings

are created through the joint actions of people engaged with one another. As Burr (2003) states, "knowledge is therefore seen not as something that a person has or doesn't have, but as something that people do together"(9).

Constructionist theorists question the hard boundary between "research" and "practice" (common in positivist discourses of inquiry) as reflective practitioners (and practice-oriented academics) are encouraged to make their own practice the 'subject' of inquiry rather than creating special situations solely for the purpose of data gathering (McNamee and Hosking, 2012: 5). As part of the movement to challenge the "knowledge claims" of positivistic inquiry, social constructionist approaches view knowledge as a negotiated agreement reached by a community of scholars (Polkinghorne, 1997: 7). Research texts are viewed as a construction rather than an accurate picture of reality – in other words, as one version of reality rather than the *only* version (Tierney, 1997: 25).

In their book *Research and Social Change: A Relational Constructionist Approach,* McNamee and Hosking (2012) suggest a more expansive and generous understanding of 'knowledge' as something that emerges out of day-to-day practice. Concerned about inquiry as a "relational practice that (re)constructs or constitutes relational realities" (xvi), they use the term 'relational constructionist' specifically to "direct our attention to *relational processes* as opposed to pre-existing (individual and social) structures" (xiv).

In looking at research as a type of 'conversation', constructionist approaches challenge conventional hierarchies of knowledge – especially the hierarchy between 'academic research' and 'practical knowledge' (Gergen, 2009; McNamee & Hosking, 2012). McNamee (2012) points out that constructionist approaches challenge the theory/practice divide by disturbing unquestioned assumptions: "theorizing is an action and it is/should be practical. Thus, in his life's work, Ken [Gergen] has collapsed the longstanding duality between scholar and practitioner" (151).

In broadening our conception of research and knowledge generation to include the "everyday-ness" of our practice/work, McNamee and Hosking (2012) suggest that we shift from using the term 'research' to the broader term 'inquiry' as it

> can seem more a part of the daily practices of those who do not think of themselves as scientists and it gives space to activities that some views of science would not count as scientific... the term 'inquiry' seems to imply an orientation towards exploration... along with a curiosity and openness to what might be (5).

In reflecting on how meaning is borne from the 'coordination of language and action' and can thus only be constituted within the context of specific relationships and interactions, Gergen (1999) suggests that "any words, phrases or sentences that are perfectly sensible to

us now could, under certain conditions of relationship, be reduced to nonsense... If we do quest for certainty, something to count on, a sense of grounded reality, it can only be achieved through relationship" (48).

Rather than viewing research as something (only) undertaken on things 'out there', and only in circumstances specially constructed for the purpose of data collection, a relational constructionist approach might make 'our own practice the subject of inquiry' (McNamee and Hosking, 2012: 5). In this sense, auto-ethnography (which connects the personal or autobiographical to the cultural) could be viewed through a constructionist lens as an approach that allows researchers to engage in critical self reflection and become witnesses or subjects (rather than merely observers) to practices of inquiry (McNamee and Hosking, 2012: 57).

Inviting practitioners and researchers to consider broader definitions of knowledge typically involves a self-reflective stance. McNamee (2012) discusses the importance of a 'self reflexive stance of uncertainty' in relational inquiry as it allows us to 'think together' to 'relationally craft possibilities' (151). Urging us to consider the importance of a 'reflexive pause' in our work, she acknowledges that a more reflective stance requires moving away from the traditional expert-driven discourses of professionalism and embracing doubts, uncertainties and an openness to relational possibilities.

In their article, 'A Crack in the Mirror: Reflexive Perspectives in Anthropology', Myerhoff and Ruby (1992) acknowledge that while notions of reflexivity are surrounded by a 'confusing and thick tangle of terms' as well as multiple shades of meaning in various disciplines and contexts, it describes the ability of any system to turn back upon itself and make itself its own object (307). Furthermore, they suggest that merely 'holding up a single mirror' is not adequate to this task as "mirrors must be doubled, creating the endless regress of possibilities and opening out onto infinity dissolving the clear boundaries of a 'real world'" (309).

While there are no specific research methods attached to relational and constructionist approaches, relationally responsive inquiry often leads us towards 'talk, conversation and dialogue', ways of working that "make space for thick textured descriptions" and approaches that use the "language of narrative or storytelling, discourse or ethnography" (McNamee and Hosking, 2012: 47). In thinking about the way we shape or construct our inquiry, McNamee and Hosking (2012) explain that *all* inquiry can be seen as a type of storytelling, as we construct a certain narrative in the process of our writing.

In looking at narratives from a relational and constructionist perspective, we shift away from seeing stories as a reflection of 'individual subjective reality' and towards viewing "action or texts as more or less local and thus embedded in multiple inter-textual relations," as emerging within local realities and, perhaps most importantly, "as co-

constructions where the inquirer is part of, rather than apart from, the narrative" (McNamee and Hosking, 2012: 50).

In thinking about the connections of relational inquiry to notions of narrative, it is useful to remember that narrative is not only a way to understand how we frame our experiences, but a way of generating knowledge, 'disrupting old certainties' and illuminating broader social processes (Andrews, et al: 117). In this sense stories are never 'wholly personal' but 'bear a strong relationship to the storylines out there' (Andrews et al, 2004: 114). While there are many ways to 'read' or understand stories, a relational perspective suggests that individual narrative are tightly intertwined with social practices and larger cultural discourses, defined here as 'a system of statements, practices and institutional structures that share common values' and which 'reflects the prevailing structure of social and power relationships' (Freedman & Combs, 1996: 42).

Constructionist approaches suggest that storytelling is intimately connected to identity construction, as in telling stories we are continually shaping our self image and our professional self (Maggisano,2008: 9). Rather than viewing narrative as a reflection of a solitary and unitary self, we can treat stories as a type of cultural discourse as "the stories that people tell about themselves are about many selves, each situated in particular contexts, and working strategically to resist those contexts"(118). The interconnections of our own stories with the larger communities we function within is expressed well by the notion that "this is my story. But it is not my story *only*" (Miller cited in Leggo, 2010).

Constructionist approaches encourage us to think of ourselves as constituted by multiple selves. We can draw on the notion of 'internalized others' as a way to acknowledge the diverse voices, views and experiences (embodiments of other relationships and experiences) that live inside of us. McNamee (1996) acknowledges that "we carry others with us." Acknowledging the diversity of voices that we embody is a way to recognize the multiplicity of relationships that we function within, and that act as resources for other ways of being in the world. "In effect, we carry the residues of many others with us; we contain multitudes" (McNamee, 2008, 16).

Kenneth Gergen also challenges the notion of individual identity as comprised of a 'coherent unit', suggesting instead that "each relationship will bring me into being as a certain sort of person... As the years accumulate, so do the laminations of possibility" (2009: 136). This notion of 'multi-being' offers a rich repertoire of ways of being in the world – shaped by our previous experiences, relationships and current contexts.

Relational constructionist inquiry highlights 'language-based construction processes' and emphasizes 'taken-for-granted ways of talking and acting' (McNamee and Hosking, 2012: 54). Making visible unexamined practices is a central concern in constructionist inquiry; this is what Greene (1995) refers to as a "cloud of givenness" – or what is considered

natural by those caught in the "everydayness of things" (47). To make discourses visible we might ask ourselves, "what discourses or language practices are we bringing to understand something?" (McNamee, Social Constructionist Workshop, November 2011). Social psychologist Vivien Burr (2003) also suggests that constructionist approaches invite us to be "critical of the idea that our observations of the world unproblematically yield its nature to us, to challenge the view that conventional knowledge is based upon objective, unbiased observation of the world... "(3).

Suggesting that a critical task for new practitioners is to 'challenge the implicit social practices that privilege some discourses at the price of silencing others', Horsfall and Rothwell (2001: 100) call attention to the taken-for-granted knowledge practices in healthcare that are neither helpful or ethical (Horsfall and Rothwell (2001). They are interested in making visible the 'received habits' of everyday practices that are 'once removed from our direct awareness or focus' urging us to expand our understanding of knowledge to include those 'small details' that lie at the margins of our practice – details that are implicitly considered too 'trivial or unscientific' to count.

In attending closely to language practices, constructionist and relational approaches emphasize the role of dialogue in opening up possibilities for more "generative discourses". This kind of dialogical communication is characterized by "reflexive attention to the ongoing process" and ways of speaking and writing that open up space for self and other (McNamee and Hosking, 2012: 68). The idea that we 'create our worlds largely through discourse' (115) encourages us to be more mindful of ways of talking that 'lock us into unwanted patterns of action' (Gergen, 1999: 63) as well as how language can be used to create opportunities for more collaborative ways of talking and writing that offer new possibilities for action.

In acknowledging that each way of constructing the world sustains (and disregards) certain traditions, Ken and Mary Gergen point out that we need to be concerned with 'whose voices are heard and whose are suppressed?'; 'who is favored and who is marginalized?' (2008: 26), while moving beyond 'antagonistic critiques' to new ways of engaging with each other. A constructionist approach to dealing with conflict might involve transforming antagonistic 'positions' through a process of grounding people's perspectives in personal experience and storytelling, rather than debating abstract concepts. This approach may open spaces to 'explore doubts and uncertainties as well as increase appreciation and sensitivity'(1999: 97). In discussing the radically different paradigms of scientific and religious world views, for example, they suggest that 'neither within in its own terms, can produce what the other offers' urging us to move beyond oppositional stances – from either/or to a position of *both/and* (Gergen and Gergen, 2008: 22).

In considering the role of language in understanding difference and encouraging dialogue, Gergen asks 'how is it that we understand each other? How do we come to share meaning (or not) within dialogue? How can people who inhabit different and conflicting realities – worlds in which 'the other' is discredited and demonized – sustain life together?' (Gergen, 1999: 142). Echoes of Wittgenstein's notion of 'ways that we go on together' [citation], underlie this kind of transformative dialogue in which we 'locate ourselves in each other' through the dance of conversation. "If your response includes the sense of what I have said, possibly concern over what I have said, then I find myself in you" (Gergen, 1999: 160).

In contrast to ways of communicating that place value on certainty and singularity, dialogical approaches are rooted in a situated responsiveness that privileges the *uncomfortable spaces* of uncertainty, multiplicity and incompleteness "which highlights how very different dialogue is from our common understandings of communication" (McNamee, 2008: 9). Dialogue is rooted in a stance of curiosity and mutuality that honours the relational back and forth of a 'conversational' metaphor. As McNamee writes, "dialogue is a process of holding firmly to one's position while maintaining a curiosity and respect for another's very different position" (2008, 8).

In challenging conventional or taken-for-granted 'truths' about the role of language in 'objectively' reflecting the external world, constructionist frameworks speak eloquently to the 'crisis of representation' in scholarship that questions notions of 'truth' and the rigid boundaries between the humanities, social sciences and the arts (Ellis, 1997: 115). Poet and academic Carl Leggo (2010) writes of challenging the 'hegemony of certain kinds of discourses' in academic research that marginalizes narrative, autobiographical, fictional and poetic ways of knowing (67).

If we understand the role of language in shaping experience and constructing meaning, we can consider the central role of language practices in daily life. As Kenneth Gergen (1999) states, "language, in this sense, is not a mirror of life; it is the doing of life itself" (35). Because language constructs our realities, we need to be mindful of dominant discourses (or 'conventional ways of talking') that can 'lock us into unwanted patterns of action' (Gergen, 1997: 63). Informed by the idea that language itself constructs meaning, and opens up possibilities for ways of acting, I turn in the next section to a discussion of narrative and relational analysis which forms the basis for this inquiry.

Writing as a method of inquiry

> I need to write it down or it doesn't exist... you never know what you want to write until you write it down. It doesn't exist as an idea all by itself...
> (Joan Didion interviewed on CBC Radio 13 November 2011)

In thinking about how narrative writing (and reading) can bring 'renewed attentiveness' to our own stories and the stories of others (Leggo, 2010), I explore the idea of writing as a method of inquiry which highlights the role of language in the construction of meaning. I then turn to an exploration of relational and dialogical approaches to narrative which highlights how we bring narratives into relationships with each other.

Echoing Didion's sentiment, Donald Spence explores the process of 'putting things into words', noting the intentional construction of meaning through writing. Interested in what he calls 'narrative truth', he states, 'It is clear that the names for things are not exactly lying around, waiting to be picked up and placed in sentences, every word marks a specific decision by the author and every sentence represents a particular overall combination of these words" (Spence, 1982: 40).

Using narrative and poetic accounts my own practice has positioned me as both author and subject of this inquiry, and reinforced the role of writing itself in the meaning-making process. Narrative researcher Jill Vickers (2002) suggests that the close connection between personal narrative and scholarly writing can be seen when the researcher's own experiences is treated as "legitimate data". This kind of approach challenges the conventional 'insider-outsider dichotomy' in inquiry and "revolves around the *process of writing* [my emphasis] – more so than other methods" (Leavy, 2009: 42).

Reminding us that the process of research inquiry encourages (and discourages) certain experiences from being written – and thus 'storied', sociologist and occupational therapist Kathy Charmaz (2002) reflects on the meanings of silence. "When and why people tell stories or remain silent not only reflects their immediate concerns but also their historical, social, cultural, and interactional contexts. What sparks stories in one context may invoke silence in another" (305). Similarly she suggests that "social scientific stories are not just there, waiting to be selected like dessert in a cafeteria but rather exist in that liminal place where the unexpected occurs... meaning is at once emergent, slippery and changing. And so it is with the research story that we tell" (323)

In reflecting on the role of writing in qualitative research, Davies (2007) suggests that postmodernism has focused our attention on the process of textualization – the process of trying to communicate experience, observation, reflection and analysis in written form which is integral to all stages of research. She points out that bringing together various

written sources to create a final research paper – including field notes, transcriptions, other research and professional literature – is fundamentally a dialogical process. The document that is produced is itself intertextual. And as it goes out into the wider academic or professional communities, other people's responses generate further dialogue as the number of voices in the text expands.

The influential work of Laurel Richardson and Elizabeth St. Pierre on 'writing as a method of inquiry' (or 'writing as data analysis') has been critical in foregrounding the relationship of writing to meaning-making. In acknowledging that writing itself creates meaning (rather than reflects or reproduces an independent 'reality'), writing becomes central to the process of knowledge production and a critical method of making sense of our lives. Richardson's (2000) statement "I consider writing as a method of inquiry, a way of finding out about yourself and your topic... [w]riting is also a way of 'knowing'– a method of discovery and analysis" (923) situates the writing process itself as a way to create knowledge.

Richardson points out that if meaning is located in the 'text' in qualitative inquiry, then writing should be given more attention. She encourages us to move away from mechanistic styles of communication to ways of writing that will hold the readers' attention. While recognizing that we can write in different styles and formats for different purposes/audiences (523), a 'writing as inquiry' approach demands that we "put ourselves in the text" (517) and understand ourselves as reflexive researchers and as "persons writing from particular positions at specific times" (518). Reminding us that conventional formats in social scientific writing are a socio-historical construction, she urges us to "release the brake on our pen and word processors" (519) and shape our writing practices to fit our purposes.

In seeking literary, rather than scientific, metaphors for social science writing, Richardson (1994) encourages us to look at "poetic representation" as a form of evocative social science as "writing sociology as poetry displays the role of the prose trope in constituting knowledge. When we read or hear poetry, we are continually nudged into recognizing that the text has constructed" (522). Arguing that poetry comes closer to everyday speech than sociological discourse, Richardson argues it is both a more practical, and more powerful, method for analyzing social worlds.

While Richardson acknowledges that few academics will turn into poets and novelists, she nonetheless encourages social scientists to view writing as a process of discovery and experiment with different writing styles as ways of engaging readers. In breaking down the boundaries between academic writing and literary writing, she encourages us to borrow skills and strategies from creative writers so that we can enhance our attentiveness to language and expand our 'writing vocabulary' (525).

Challenging the idea that writing merely 'reflects' or 'summarizes' the data (and is of secondary importance to the 'real' activity of data gathering), Elizabeth St. Pierre in 'Writing as Method' (2007) describes writing as a method of inquiry as a research practice involving the foregrounding of how researchers construct knowledge about people, themselves and the world by writing. Acknowledging the influence of the 'linguistic turn' in social science that challenges the idea that writing 'represents' external reality, St. Pierre (2007) states:

> many social science researchers no longer assume that language is transparent and can simply mirror or represent reality; rather, they understand that language helps to create reality. Writing is therefore not an objectifying practice or a mopping-up activity at the end of a research project but a creative practice used throughout to make sense of lives and culture, to theorize and to produce knowledge.

This approach challenges the idea that 'data collection' is a distinct 'stage' of research – able to be separated from thinking and writing. More importantly this challenges the unexamined assumption that writing is a less important activity after the 'real' research has been conducted. Collapsing the (false) dichotomy between inquiry and writing, these theorists challenge the idea that writing is purely a 'description' of something else independent of how we construct it. Writing thus emerges as a form of thinking and analysis, as it is through the process of writing that one begins the process of 'sense making'.

> ...this analysis if much more complicated than what is usually called data analysis – positivist practices of coding data, sorting it into categories that are grouped into themes that become section headings in an outline that organizes writing in advance of writing. Those practices ignore the work of writing as thinking, as analysis. They assume that writing only documents what is already known. (St. Pierre, 2007)

This reconceptualization of the role of writing in social science inquiry represents a departure from conventional social science practices and offers rich possibilities for expanding our understanding of knowledge and viewing the role of researchers differently. As Richardson points out, when we view writing as a 'method of analysis', we imply that it is language itself that constructs the world and allows us to re-create ourselves and our relationship to others. Reinforcing the idea that writing is thinking and that "writing takes us places we might not have gone if we had not written" (St. Pierre, 2007), Richardson reflects on how writing was a way to reconstitute herself following a serious accident and loss of memory:

> Although I could not bring into speech what was happening in my head, I found that I could write about it. If I could not find the word I wanted, I could

> write its first letter or leave a blank space. In writing, the pace and the issues were my own... Writing allowed me to record little thoughts, to revisit them and fill in the blanks, to piece them together, thought-by-thought... Writing was the method through which I constituted the world and reconstituted myself. Writing became my principle tool through which I learned about my self and the world. I wrote so I would have a life. Writing was and is how I come to know (2001: 33).

Vivienne Elizabeth (2008) explores the use of writing as a reflexive tool in understanding traumatic experiences. Viewing such writing as a source of rich 'data', she challenges the idea that writing within the social sciences transparently records the research process and findings. "As such, writing is presented as the final step in a supposedly orderly research process, occurring well after the researcher-writer knows what they want to say; we 'write up' already existing findings, rather than discovering our findings in the process of writing" (p.3). She suggests that writing is a way to engage research participants in making-meaning around both ordinary and troubling dimensions of their lives and allows social scientists to 'diversify the manner in which they engage with research participants, the kind of material they collect and, hence, the kinds of research accounts they might produce'" [48].

In reflecting on the importance of alternative forms of writing, sociologists and autoethnographers Art Bochner and Carolyn Ellis (Holman, 2004) reflect on the publishing of an 'ethnographic alternative' series stating that " our idea was, again, not necessarily to work against mainstream orthodox research goals as much as to open up a whole new range of possibilities for people who wanted to think first about writing accessible prose, telling stories... being reflexive, being in their own work" (92).

In calling attention to the often neglected role of writing in qualitative inquiry, as well as to the shifting professional identity of social scientists, Bochner encourages academics to embrace narrative metaphors in their work and "think of themselves as writers" rather than researchers:

> Art: That brings us back to the question of how the graduate curriculum should change in these disciplines. That's where writing comes in. Stacy, you're teaching performative writing, I'm teaching a writing workshop, Carolyn is teaching auto ethnographic writing. Exposure to good writing is a novel idea in graduate education. I like Laurel Richardson's (2000) point about how little that is published in orthodox, mainstream journals is actually read.
>
> Stacy: And how important it is that people think about their writing.
>
> Art: And think about themselves as writers... We "train" graduate students to think of themselves as researchers, as intellectuals. But up to this point we have

> never had a mission to have them think of themselves as writers and to live as writers. What is the life of a writer? (excerpt from interview with Holman, 2004: 91).

In building on the notion of writing as a meaning making process, I turn my attention now to writing as a form of relational inquiry. While notions of 'writing as analysis' and 'writing as inquiry' foreground the critical role of writing in the construction of knowledge, relational approaches foreground the role of writing in constructing relationships and openings for new conversations with one another.

Narrative as a social process

> We are all continuously involved in the process of adding new stories to the sustaining fictions of our own biographies, of accounting for 'how things are'. The whole biographical process is a narrative-making endeavour. Stories are renewed, reconstructed or abandoned, but are always central to the individual's presentation of self and sense of personal identity. (Elwyn & Gwyn, 1998: 171)

> Despite the illusion of closure, stories are necessarily interrelated with aspects outside their control. They contain multiple references and traces of other stories by many different authors, and they are interpreted from multiple points of view in different contexts... Instead of bringing closure, the contextual/intertextual realm opens a story to multiple readings, references, associations and constellations of stories. The control of meaning shifts from the intentions of the author to the role of the readers within particular cultural contexts. (Potteiger & Purinton, 1998: 54)

Ideas related to *dialogue* are closely connected to relational constructionist understandings of inquiry. While the literature on dialogue in social science inquiry is multifaceted, Cissna and Anderson (1998) use dialogue to call attention to the interactive moment – as a metaphor of 'turning towards each other' as "the basic character of such a dialogic moment, therefore, is the experience of inventive surprise shared by the dialogic partners as each 'turns toward' the other and both mutually perceive the impact of each other's turning" (74).

While narrative inquiry encompasses a broad range of research and writing practices and narratives may be 'gathered', 'constructed' or 're-presented' using a variety of methods (Trahar, 2009), I am interested in approaches informed by relational and dialogical

metaphors. I am drawn to the idea of narrative inquiry as a form of relational practice, or way of 'leaning towards each other' (Pelias, 2011: 13). Like Pelias I am interested in drawing from personal narrative, autoethnography and poetic inquiry to "make sense of individual experience while remaining culturally situated to offer alternative ways of living" (12).

Dialogical methods are a way to connect with others – to lean in and witness 'one writer struggling to make sense of personal relationships'. Seeking to understand the role of language in relationships, or 'how I live my life with others', Pelias states

> I am drawn to language, to speech acts, to communicative exchanges as the most telling aspects of my personal relationships. I learn in through language; I distance myself through language; I negotiate meaning through language. In short, I language my way into being a social being. Constituted in interaction, I am formed by the language that passes between me and others... My relational life is a story of language, of communication, told in the words that I can muster. (2011: 17-18)

While a full examination of notions of dialogue is beyond the scope of this inquiry and precise definitions of dialogue in postmodern theories are hard to 'pin down', dialogue can be viewed as those momentary interactions where all meanings are imagined to be contingent and contextual and where collaboration and intersubjectivity are emphasized as "the new concern for dialogue concentrates, therefore, on contingent, emergent, and discordant difficulties of human linguistic existence rather than on proceduralist dialogue" (Cissna and Anderson, 1998: 79).

Informed by the work of philosophers Martin Buber, Mikhail Bakhtin and others, dialogue can be seen as the (unpredictable) moment where we influence the other – and the other influences us. As Cissna and Anderson (1998) state, "each utterance, each interchange, sets the stage for new surprises in ensuing moments of meeting" (87). In turn, post modern and constructionist notions of dialogue emphasize 'polyphony' – or the presence of multiple voices – and the processes of 'relational and emergent realities' (94).

My writing and analysis is informed by this emphasis on multiple voices into a single text in various ways. The integration of multiple practitioner/writers, and the linking of their narratives with each other (and myself) create opportunities for collaborative conversations. In conceptualizing writing as primarily a dialogical (or relational) activity, we also acknowledge that we are always addressing some kind of real or imagined audience. A sense of audience is thus implicit in our writing and shapes both what and how we communicate. In this case, I am writing to multiple audiences – primarily practitioners, educators, those interested in narrative inquiry, and relational constructionist approaches.

Sheila Stewart (2010) echoes this emphasis on the negotiation of meaning through language as a relational process. In her reflections on poetry she writes that, "poetry is a call

and response. The poet *and* listener create the poem in the listening. Learning is like that too. We learn toward another, the learning alive between us"(101). Ideas about dialogue also inform Arthur Frank's understanding of narrative analysis as contributing to an evolving and expanding conversation. In his article 'What is Dialogical Research, and Why Should We Do It?', Frank (2005) frames inquiry as a collaborative effort – constituting a shared space between researcher/writers and 'those who tell stories'. Urging us to look at social science inquiry as an open-ended process, Frank states, "each voice is formed in an ongoing process of anticipation and response to *other voices*. Each voice always *contains* the voices of others" (Frank, 2005: 966). As he states, "rather than carrying the monological message, this is all you are, dialogical research can offer the possibility, *this is what else you are connected to*..." (Frank, 2010: 102).

In his article on dialogical autobiography, Frank challenges the (dominant) idea of memoir as a reflection of individual experience. Focusing instead on the relational dimensions of practitioner memoirs and patient narratives, he views these texts as attempts at dialogue between the author and others. Rather than viewing illness memoirs (i.e., personal accounts of illness) as a reflection of a 'coherent' and isolated self, Frank encourages us to see the writing within the context of multiple relationships and conversations in the author's life. "I want to consider stories that seem to be constructed on the alternative principle of a consciousness that is not monological (unitary, centered, having the last word) but dialogical" (Frank,2005).

In exploring the blurred relationship between text, writer and reader in women's memoir writing, Hammerwold (2005) also suggests that the transformative power of personal story lies in its ability to bridge difference through the connection with someone else's experience – even if it bears little resemblance to the life of the reader. Suggesting that personal narrative has elements of both *conversion* (change) and *conversation* (dialogue) she states:

> Neither self nor community exists autonomously. Memoir is a site of transformation and building bridges across difference because it allows the reader to get inside the experiences of another person. It is a dialogical relationship, existing both individually and collectively... Reading memoir has an influence on the reader, whether positive, negative, or indifferent.[19]

Drawing on Bakhtin's writings about dialogue and 'polyphonic' (multi-voiced) narratives in literature, Frank makes the point that the 'totality of suffering' that accompanies serious illness is compounded by disconnection from others. It is this lack of meaningful relationship between those that are ill and those that are not (and thus between

[19] Accessed 4 November 2012 from www.thirdspace.ca/journal/article/viewArticle/hammerwold/138.

patients and healthcare providers), that creates a deep divide. In exploring some of the tensions in creating dialogue through illness he states:

> deep illness itself is not necessarily brokenness. Brokenness means exclusion from relationships that have two aspects. One aspect is being in dialogue, attending to the other's speech and having one's own speech attended to; the other aspect is mutual respect for difference, expressed by neither assimilating the speech of the other. These aspects are complementary but also in tension: dialogue can tend to assimilate otherness, and otherness can pull apart dialogue. Illness is only contingently related to brokenness. (Frank, 2005)

Frank is most concerned with the ethical imperative of narrative to bridge that divide and thus address the absence of dialogue and exclusion from relationship. Seeking an 'ethical' theory rather than a purely 'descriptive' one – what should be, not only what is, Frank makes a case for the importance of remaining in dialogue with each other. His analysis of illness autobiographies reminds us of the moral obligations we have to each other.

If we view narrative is a fundamentally social process, then acts of storytelling can be understood within the many conversations in our lives. It is not just that people tell each other stories, but rather that "the turn-taking, responsive relating of people may be thought of as forming narrative at the same time as that narrative patterns moral responsibility and turn taking" (Engel et al, 2008: 83). In this sense, narrative can be viewed as a way to understand the 'silent private conversations' (Engel et al, 2008: 82) that we all continually engage in – and that affect the way that healthcare providers and patients interact.

Frank's interest is in exploring how we can learn to "live better with the stories that surround and circulate through our lives" ((2010). In his most recent book, *Letting Stories Breathe* (2010), Frank more fully explores the idea of dialogical narrative analysis drawing on the concept of *socio-narratology* where the focus is on stories as actors. Rather than viewing stories as a portal into the mind of the storyteller, he is interested in what the story does.

Frank speaks of narratives as resources for connection and disconnection (2010: 43), suggesting that it is the 'continuum of stories', and the interconnections between them, that is most relevant in narrative analysis. "Each form of storytelling – fiction or non-fiction, folklore or journalism – teaches people how to make sense of stories in other forms... each form does its own distinct kind of work, but those works depend on each other" (Frank, 2010: 16).

In reflecting on the relational potential of stories, Frank suggests that it is the effect of stories on readers/listeners that speaks to their usefulness and their capacity to act as resources stating "dialogical storytellers... know their stories are interpretively open and out of control, and dialogical listeners respond with interpretive openness" (Frank, 2010: 36).

This echoes Carolyn Ellis' reflection on narrative that the experience is "always more than can be put into the text and less than the text tries to tell... for me, the question had become not whether narratives convey precisely the way things actually were, but rather what narratives do, what consequences they have, and to what uses they can be put " (Ellis, 2009, 110).

Narrative can foster connections through the establishment of a community of writers/tellers and readers/listeners. In examining the importance of patient narratives in healthcare practice, Julia Connelly (2002: 145) writes,

> Narrative knowledge allows and encourages human connections. One shared story often triggers the telling of other stories by involved listeners, facilitates memories and personal reflections of past experiences... creates an expanded awareness of the moment, including a recognition of the power of personal presence and connectedness... without narrative, deep human contact is very difficult, especially in the setting of present day medical practice.

Emphasizing the co-creation of meaning through poetry reading, Jane Hirshfield (2007) suggests that writers offer just enough information for the reader to know what 'terrain' they are in, and then the reader is called upon to complete the work (22). Likening narrative to an unfinished canvas, she emphasizes the role that the reader plays in completing the story stating "the reader as well as the writer must bring the full range of memory, intellect and imaginative response... the best stories... support alternative readings, different conclusions" (28).

This echoes Brett Smith's approach to narrative analysis where he urges us to 'let stories work on us' and ask ourselves questions which focus us on the relationship of readers to the text including: 'how does this story resonate with me?' and 'where will this story take me?'[20] Focusing on our own response to stories echoes Frank's (2004) suggestion that instead of attempting to *analyze* stories we should think *with* stories, letting them analyze us by noticing what attracts [us] too them, and what we resist about them (6-7). Frank's (2010) emphasis on the circulation of stories or "who is caught up in which story and who tells that story again" directs our attention to the relationship *between* various texts and how "stories echo other stories".

Informed by ideas regarding *intertextuality* in contemporary literary theory, which seeks to understand stories not as isolated entities but within the context of other narratives, a dialogical approach recognizes the value of 'bringing together voices that are not yet in

[20] "Narrative analysis as a turn to theory and angles of vision." Presentation at the Centre for Critical Qualitative Health Research, University of Toronto, Nov 2010.

dialogue with each other. This provides possibilities for exploring not only how things are, but 'how things ought to be'.

Making reference to the close interconnection of texts, Frank (2010: 37) emphasizes how each story is embedded in a web of other stories. Informed by the idea that "stories are portals into other stories", Frank draws our attention to the notion of resonance acknowledging that most resonances are unintended by the storytellers as:

> no one ever makes up a story by him – or herself, and no one ever tells a story all by itself, dissociated from any other stories. Any story is shaped by the other stories that the storyteller and listeners know... Stories are textures of resonances.

Interested in how a dialogical understanding of narrative can contribute to our understanding of narratives in healthcare practice. I would agree with Frank (2004) that if we "bring stories together to reinforce each by its complementarity with others... stories stand better together, each increasing the resonance of others like it" (4-7). Drawn to the idea that narrative researchers bring stories together in particular ways, and highlight their resonances, I turn now to an exploration of social poetics, the relational poetic and relational poetry which further constructs our framework for understanding healthcare narratives as a form of dialogical inquiry.

Dialogical inquiry, social poetics and relational poetry

> Poems are for everyday use like paper serviettes. You don't have to save them for company dinners on Sunday like the Irish linen and the sterling silver. They're disposable. Commit them to memory and throw them away.
>
> Shirley Serviss[21]

J: You mean, that the way modern art refuses to tie things down gave you more space to explore, think and feel outside 'your box' so to speak?

C: Yes, that's it, that's what I was trying to get at there. If we argue that post-modern research writing is less of a pursuit of truth and more of a contribution to an ongoing conversation, then is it possible to pursue a genre of writing that is not constrained by discourses of description, linear argument and conclusion?

J: You're not saying that that linear argument, with the presentation of evidence has no worth are you?

C: No, I don't think that would be wise, but isn't there space for a different form of academic writing? Isn't there room for an alternative form of publishing and engaging with research material? It's more a question of whether the academic celebration of linear argument denies us the ability to 'hear' other ways of constructing realities. Poetry provides one such genre of communicating, as attention is focused on the relational process of meaning making rather than meaning understood.

J: How does it do that?[22]

---

[21] Excerpt from 'Poem for a ward clerk' in Serviss 2005.

[22] Excerpt from Ramsey, 2011.

I have begun this section with an excerpt from Ramsey's article on the use of poetry to create relational space in inquiry to situate poetry as an alternative form of academic writing – and a powerful method for dialogical inquiry. Poetry is well suited to "tentative explorations" and offers us alternative ways of constructing realities. In particular, poetry allows for the exploration of uncertainties and provides a "spacious environment for dialogic, academic exploration of issues within social sciences. There is something carnivalesque and unfinalisable in the poem and relationship between poet and reader" (Ramsey, 2011: 24). While acknowledging that poetry can be evocative, Ramsey encourages us to focus on the ways that poetry can be "provocative of new relations with reader-as-other" as it provides "a spacious arena for joint meaning making between reader and poet" (18). Informed by Shotter and Katz's (1996) work on social poetics, Ramsey suggests that the structure of poetry itself "acts as a conversational partner" and lends itself to the co-production of knowledge. Poetry, as a writing form, can 'strike' or 'move' readers differently than conventional academic prose and is a 'spacious medium for readers to join with the writer in joint construction of meanings' (15).

Wright et al (2010) reflect on the role of poetry in promoting critical reflection and helping navigate "those 'in-between' spaces where critical learning can occur... These transitional spaces are where our knowing is incomplete and unfinished... Reading poetry encourages a way of knowing and experiencing the self and others that allows the ambiguities inherent in critically acting in a complex, disparate world" (118). Looking at poetry as a form of evocative inquiry, we can write from our own reflections or co-create accounts of practice with others (Prendergast et al, 2009). As Ramsay (2011) points out, poetry provides a way to focus attention on dialogical processes of communication as she writes: "In writing a poem I do not seek to convince or overpower alternative treatments of this subject. Instead I invite response in a dynamic form: a conversation" (22).

While acknowledging that poetry can provide a generative resource for dialogical inquiry, I turn here to an exploration of the concepts of 'social poetics', and the 'relational poetic' (Shotter, 2010; McNamee, 2000; Shotter & Katz, 1999; Katz & Shotter, 1996) as a framework for exploring narrative writing. In her article "The Social Poetics of Relationally Engaged Research," McNamee (2000) discusses inquiry itself as a form of relational engagement and encourages researchers/writers to embrace the idea of *social poetics* as a way to focus on the meanings created in relationship with each other.

This view of knowledge as part of an ongoing dialogue – or 'what people do together' – challenges individualist understandings of writing as the creation of a solitary mind. Instead, McNamee urges us to see the poetic moment as that which is generated within relationships. Acknowledging that 'to talk of the poetic is to give wing to the imaginative' and to 'express oneself in words that are thoughtful,' McNamee (2000: 146) invites us to shift our attention from the interior of the poet, or a particular poetic moment, to the 'relational

nexus from which all meaning emerges.' If we are no longer 'trapped within individualist discourses', which view the poet as an isolated entity, we can focus on the relational possibilities of writing. "By unsettling the notion of poetics from its individualistic tradition, we open exploration for the relational ways in which the imaginative, the unsettling, the novelty are crafted in what people do together" (McNamee, 2000: 146).

Drawing from dialogical metaphors for practice and inquiry, Shotter (2010), Shotter & Katz (1999) and Katz & Shotter (1996) encourage us to step outside our objectifying professional *gaze* to embrace a 'social poetics'. This involves talking 'with' clients, rather than 'about' them and focuses on people's immediate, embodied responses to each other (Shotter, 2010: 63). Drawing heavily from the work of Wittgenstein in their discussions of dialogical inquiry, Shotter and Katz (1999) encourage a more 'conversational' way of talking and writing about practice which focus us on the spontaneous and unfolding 'interactive moment' in which communication occurs.

Katz and Shotter (1996) draw our attention to the often ignored moments in practice – those events that 'might otherwise escape our notice' (919). In their article on a social poetics of diagnostic interviews, Katz and Shotter (1996) focus on the role of 'arresting, moving, living or poetics moments' that occur in clinical interactions and moments of "epiphany that occur in the delicate negotiations between [health professionals'] worlds and those of the patient" (919). They suggest that a poetic relational stance involves 'boundary crossings' as we position ourselves to navigate, or move among, different languages (i.e. the ordinary language of the patient and the rhetoric of diagnostic discourse). They urge us to pay closer attention to those unfolding 'arresting moments' – when we are struck by what has been said – which create pauses for reflection and the opportunity to expand meaningful dialogue (929).

Katz and colleagues (2000) discuss their project to integrate community elders in the training of medical residents. Informed by an interest in bringing together multiple perspectives and creating opportunities for learning, they point out that this kind of conversation encourages dialogue outside the usual social hierarchy as "we treat their everyday life world as a world of respect and importance by using *its* language, the language they speak" (859). Perhaps most importantly, this kind of 'dialogically interactive' practice creates opportunities to move patients' voices from the margins of medical discourse into a more active role in the negotiation of meaning. Speaking about her role as a "collaborative consultant" in medical interviews, Katz reflects on navigating different worlds of meaning:

> I am involved in voyages of boundary crossing, navigating worlds of difference; making room for another person, a different point of view or stance, opening up a new space between patient and doctor…[m]y shifting position, betwixt and between, is a moving liminal position with formative but not

> coercive power… new meanings suggest themselves as I let the patient's words resonate and reverberate within me – a dialogical invitational stance. (Katz & Shotter, 1996: 920-21)

A social poetic (or relational poetic) approach is an embodied view of communication characterized by a relational-responsive understanding of people's everyday practices. "[L]iving people bodily respond to each other's utterances and voicings, and in so doing, not only do they relate themselves to each other, but they also relate themselves to their surroundings" (Shotter and Katz, 1999: 2). Shotter's (2010) notion of the 'poetic' is any evocative form of writing which invites the listener/reader in. This relational view of writing emphasizes the inter-subjective space between text and reader/listener and acknowledges that which we may not otherwise notice (Shotter, 2010).

This calls for a turn to more 'everyday' forms of inquiry – what poet Jane Hirshfield (1997) calls 'the importance of the common' (14) – which can honour the relational complexity of day-to-day practice. Social poetics can be understood then as a way to call attention to the taken-for-granted and previously unnoticed aspects of our lives (the 'fish being the last to discover water variety' (Shotter, 2010: xii), and a way to bring these into relation with each other. Interested in calling attention to such 'background practices' that go unnoticed and unacknowledged in professional practice, Shotter (2010) asks "what is it that we have been trained to do in practice that we must now, so to speak, 'undo'?" (59).

Positioning himself on the 'edge' of social constructionist theory, Shotter (2010) is interested in ways of being together that embody certain sensibilities. In trying to focus on 'living moments' that 'continuously unfold in time' (vii), he is most interested in inquiry which flows from the continuous stream of everyday life and is situated in local contexts and meanings. Suggesting that the function of a social poetics could be to encourage more relationally responsive conversations which put our routine realities on 'freeze frame' and 'pauses' (Shotter, 2010: 48) then social poetics can be seen as a kind of reflective space to stop and let 'each other's utterances resonate' within us before responding (48).

Cunliffe (2002,#1) also suggests that social poetics is a way of exploring how "in the flow of our embodied dialogical activity, we relate to our surroundings and make sense of our experiences" (128). If social poetics embraces a dialogic approach to inquiry, Cunliffe suggests we ask ourselves how we might use social poetics to recognize how "we make sense and shape our lives through our intralinguistic activities" (129). In understanding language as the basis for dialogical inquiry that explores our social realities and identities, language can be viewed as metaphorical, indeterminate, and ambivalent. "In other words, meaning is created as language plays through us, as words, sounds, rhythm, and gestures evoke verbal and emotional responses" (Cunliffe, 2002: 129, #1).

In thinking about the importance of reflexivity in constructionist inquiry, the practice of social poetics challenges the detached omnipresent voice of the researcher and repositions the researcher as someone who experiences "the play of language and is not separate from the process of meaning making" (Cunliffe, 2002: 134, #1). If we understand meaning-making as a form of embodied and situated dialogue, then social poetics offers a 'discourse of everyday conversations' (Cunliffe, 2002 #2) and "a way of exploring how, in the flow of our dialogical activity, we relate to our surroundings and make sense of our experiences... a social poetics elevates everyday, imaginative ways of talking – for example, metaphors, storytelling, and gestural statements" (Cunliffe, 2002: 128, #1).

If language shapes meaning throughout the course of everyday conversations, then poetic language can be a useful resource for conveying "complex and multilayered meanings" (Cunliffe #1, 130). As social poetics is concerned with the poetic quality of everyday language, it offers potential for exploring new forms of knowing that focus on 'practical and tacit understandings' (Cunliffe, 2002, #1), and taken-for-granted understandings of everyday practice.

Notions of *resonance* and reverberation are central to our approach as social poetics focuses on how the words of others 'move us' or 'strike us'. In other words, how we are 'taken up by a dance, a piece of music or piece of writing' (Shotter, 2010). Emphasizing the responses evoked in us by a phrase or piece of writing, resonance is something that 'flares up our imagination' – where we are struck by someone else's words which resonate to a whole "multiplicity of other new possibilities" (2010: 44). In focusing on what it takes for a text to speak or stirs us, for example, we are invited to pay attention to specific phrases or images that provoke a response in us; in other words, what '*strikes a chord'*.

In exploring how images and events from someone's story may resonate with our own, Maggisano (2008) discusses how our response to others can open up possibilities for different kinds of action. Suggesting that resonance exists at that point where our own story overlaps with someone else's, where we share certain aspects of the story or can identify with the story or the character. This fusion of meanings "opens up a richer repertoire of possibilities for me. It may also corroborate feelings or perspectives that I have felt but was isolated in... these resonances encourage us to explore, 'Can things be different?, Do things have to be this way?" (10).

Informed by Tom Andersen's influential writings about reflective practices in therapy, and the intention to create open conversational practices which invite different meanings, Shotter is interested in constructing new ways of understanding and new ways of 'going on' by 'interconnecting and relating old facts in new ways' (Shotter, 2010: 43). It is out of such dialogical moments that 'crucial change' emerges (52). Shotter suggests that the idea of a social poetics invites 'new ways of talking, new images and metaphors' that provide new

ways of understanding' (23). Cunliffe (2002, #1) also suggests that poetic ways of speaking and writing focuses us on possibilities, rather than actualities, and provides a way to frame inquiry as a relational embodied process:.

> Thus, poetic forms of talk do not give us information about an already structured situation but help "us form or constitute for the very first time, a way of orienting toward or relating ourselves to our surroundings and the circumstances of our lives" (Shotter & Cunliffe, 2002). From this perspective, poetics is also social because how we come to know, be, and act in the world is both created in, and a product of, our responsive engaged action with others and self, that is, a way of relating in talk (dialogic). Consequently, managing and researching are reframed as embedded interactions that draw on everyday, metaphorical, and poetic ways of talking. (Cunliffe, 2001a: 133)

In this more conversational way of understanding, poetry can act as a reflective pause (Frank, 2010) as we take in the image or phrase of the other, and find ourselves resonating 'to a whole multiplicity of other, quite new possibilities' (Shotter, 2010: 45). The 'continuously unfolding relations' that occur between ourselves and others (Shotter, 74) can be understood as a process of seeking and creating connections. In the "moments when a speaker pauses after having finished his utterance, and awaits another's response to it. For it is in such moments as these... that we must responsively bridge a gap or an opening"(Shotter, 2010: 45).

Drawing on Bachelard's discussion of poetic images, Shotter emphasizes that "in the reverberations we speak... the image offered us by reading a poem now becomes our own'(cited in Shotter, 2010: 45). Similarly, in his discussion of reflective practices in therapeutic conversations, Michael White explores how hearing certain images in someone else's story sets off reverberations that reach into the our personal history. Also informed by Bachelard's understanding of resonance, White discusses how hearing another's story can 'light up' certain experiences in our own as "specific experiences of historical events come into memory and form a story-line... and endow previously remembered experiences with a new significance"(White, 2010: 102).

Shotter's understanding of social poetics strongly echoes Pelias' (2011) writing about the 'struggle for speech' in critical moments. "As I struggle for speech, I find myself physically and psychologically heightened, momentarily speechless, feeling inadequate to the task but with a surplus of possible actions, torn between my own and the other's concerns... " (39). In recognizing the connection of his own words to the larger stories circulating around him, Pelias describes the process of 'writing by association' as one thought triggers the next... to tell how the accumulation of experiences creates a sense of self (Pelias, 2011: 42). Writing out of an ethical commitment to reach out to others he states, "I am nothing more than my interactions with others" (Pelias, 2011: 50).

Gail Simon (2010: 254) writes about the impact of hearing or reading a story as a form of resonance as well. In her unpublished paper 'Writing as Talk' she draws on the idea of writing as a form of reflexive dialogical inquiry as it contributes to the ongoing 'storying' of practice.

> Writing can be considered a systemic practice in that it is always relational whether in response to inner dialogue or as part of outer dialogue. Writing from within and about professional relationships is deserving of ethical consideration as other areas of systemic practice. Reflexive writing invites critical and appreciative consideration of the fluid and emergent relationship between practice and its storying process which produces 'theory'.

The idea of a social poetics embracing a self-reflexive stance brings to mind Clifford's (1986) ideas about cultural poetics and, in particular, his view of inquiry as an interplay of voices in which we move from the metaphor 'observing eye' toward 'expressive speech'. Todres and Galvin (2008) similarly call for more poetic ways of using language "where we listen to what people say in order to *carry forward* the meanings that these words open up". They encourage writer/researchers to act as evocative mediators in offering words that open up the 'between' of inter-subjective space (571).

Interested in the ability of narratives to call forth specific responses from readers through the 'evocative quality of poetic language', they encourage us to look at what emerges in the inter-subjective space of writer (or text) and reader. Moving away from the idea that writing prescribes certain meanings, they are seeking a more open ended approach to language which emphasizes resonance and poetic language.

> We are arguing that there is more meaning in a language that is expressed in this way than in a language that is overly defined and summative. It could paradoxically be argued that language that is too definitive in its conclusions is limiting. Thus as evocative mediators we offer words that can open up the 'between' of intersubjective space. (Todres and Galvin, 2008: 161)

This emphasis on resonance "stresses narrative as a social act highly sensitive to context, something constructed 'between' text and reader" (Mattingly, 1998: 16) and calls our attention to the diversity of responses to any particular text. This is what Elizabeth St. Pierre (2007) refers to as 'excesses of meaning' as people bring their own lived experience to the texts they hear or read. Readers are thus invited to "revise the text by filling in the gaps, bridging the abyss, connecting the dots, and supplying the missing links. In these actions, readers and listeners create meaning together. Readers are convinced, not by appeals to another's authority or logic, but by their own immediate experiences in making meaning"(Warnock, 38).

This approach acknowledges that all understandings of a particular text are both enabled, and limited, by the reader own perspectives. Using the metaphor of the horizon to discuss this interplay of shared understanding and difference, Frank states,

> no two people's horizons ever overlap entirely, but neither do these horizons completely diverge. Dialogue requires difference, or else people would have nothing to say to each other. Dialogue also requires similarity or else people would have no basis for understanding what others say. (Frank, 2010: 94)

In recognizing that readers, writers and autobiographical texts are 'inextricably linked' (Hammerwold, 2005), we can view meaning as something produced collaboratively between text and reader. In this way, we open up multiple possibilities of meaning. No longer a single authoritative reading of a text, "multiple sources of local – and possibly contradicting – authority replace master authorities; instead of being monolithic and hierarchically given, meaning is apprehended collaboratively, by the reader and the writer..." (Charon, 1998: 2). While meaning is produced collaboratively between writer, text and reader, so too can meaning be co-constructed through the interweaving of different texts in dialogue with each other. We turn now to a discussion of 'relational poetry' to explore another dimension of dialogical narrative inquiry.

Here am I.
Can you see me
Standing before you
Right behind you
Singular and solitary.
in the shadows and light?[23]

Informed by an interest in collaborative meaning-making, and an interest in the co-construction of practice knowledge, social work professor Stanley Witkin introduces the notion of 'relational poetry' as a creative form of shared inquiry. Challenging the idea of meaning-making as 'private or locked away inside an individual' (McNamee 2006), Witkin encourages us to think about poetry as an opportunity to construct more collaborative conversations through poetry.

Witkin (2007) defines a relational poem as follows: a freestanding poem is responded to via an interweaving of a second poem within the lines of the first. He illustrates this form

[23] Excerpt from Gergen-Witkin relational poem in Witkin, 2007.

of co-constructed knowledge through a textual dialogue between himself and Kenneth Gergen – demonstrating not only the evocative quality of poetic writing through the careful attention to language and aesthetic structure, but the possibilities of newly crafted meanings arising from the relationship of the two texts. As Witkin himself notes, "The 'conversation' is ongoing and could extend indefinitely" (478).

Akin Taiwo's (2011) article 'Relational poetry in the expression of social identity: creating interweaving dialogues' uses relational poetry to explore issues of identity and marginalization. Interested in the 'inter-subjectivities of the human experience and the co-construction of meaning arising from multiple experiences' (1), Taiwo is interested in bringing marginalized voices, as well as our multiple standpoints, into the conversation. Speaking to issues of exclusion, as well as the possibility of creating new realities, he states, "it is the interweaving dialogue to which I have brought my multiple selves... I experience exclusion and marginality from almost all facts of the Canadian life, mostly silently, for not everything can be named. Yet at this point in time, I believe that I am creating a new reality by my presence in this particular poetic space" (3).

Using the structure of relational poetry as set out by Witkin, Taiwo generates a response to a poem previously published by social worker Martha Kuwee Kumsa about a sculpture of a "black women with no name sculpted by a white woman with a big name" as a way to express "two voices addressing common themes but from different perspectives. It is the co-construction of meaning arising from multiple identities of the self" (2).

Strangers meet
Strangers don't meet. Friends are born to
Self encounters Other
For the Other is in Self; the good knotted in bad and ugly
Image find object, body meets shadow
The shadow is the Other. Present when there's light

In the Kumsa-Taiwo relational poem (excerpted above), Taiwo (2011) makes use of relational poetry to explore issues of identity and marginalization in which the author attempts to "highlight the co-construction of meaning arising from multiple experiences... for me, my poetic insertion is my conversation with Kumsa [writer of original poem]; it is the interweaving dialogue to which I have brought my multiple selves" (3).

Also interested in the use of poetic language to co-create accounts of therapeutic encounters with clients, narrative therapist Christopher Behan further explores the idea of poetic speech in his article *Rescued Speech Poems: Co-authoring Poetry in Narrative Therapy*. Poetic speech refers to the words drawn directly from conversations with clients (specific

words, phrases, and images that strike him) that he uses to construct poems as part of a therapeutic relationship.

Commenting on the collaborative aspect of this form of writing, Behan (2003) talks about checking with clients about what he is recording during sessions, and asking "is this how they wish to say it? Is this important to them"?

> this constant process helps to assure that the voice of the person who's consulting me is privileged. At the same time, I am actively co-authoring by shaping the beginnings of the poem, retaining the client's preferences, searching out colourful language, juxtaposing problem saturated and preferred accounts, editing byroads, looking for contradictions and openings.

The use of a more relational and dialogical metaphor for inquiry provides opportunities to acknowledge the 'messiness' of practice, the presence of multiple voices as a poem may be considered an expression of ongoing conversations in the poet's life (Witkin 2007). As Ramsay (2011) writes, "Just as poetry provides space to circle an issue or theme, so it also provides a medium in which multiple voices can be heard" (22). I would suggest that dialogical approaches, drawing on ideas from a relational poetic and relational poetry, offer us a way to honour the many visceral ways in which we move others, and are moved by them (Shotter, 2010).

The idea of relational poetry, which seeks to create some kind of conversation through poetry, echoes the dialogical 'imperative' to create something together which neither of us could do alone (Cissna & Anderson, 2008). In reflecting on her longstanding partnership in creating collaborative poetry with another writer, Denise Duhamel states that she and her co-author have found a third voice – a voice that is neither of theirs individually and more than the two put together: "a voice that is neither Maureen's nor mine, but rather some poetic hybrid."[24]

The interweaving of ideas related to dialogical narrative, social poetics and relational poetry provide a useful method for inquiry and a conceptual framework for the following discussion. Focusing on dialogue created *through* poetry provides a way of approaching inquiry as I incorporate my own accounts of practice inspired by, and in response to, poems by other practitioners that have 'struck a chord' with me. This kind of dialogical approach offers a way to view individual poems as part of a larger conversation (with both myself and other texts).

---

[24] From *Poetry and Collaboration* by Denise Duhamel and Maureen Seaton. Accessed 7 November 2012 from www.poets.org.

If we view narrative as a 'semiotic companion' or partner (Frank, 2010), then we need to pay close attention to how narratives act as resources for different ways of understanding practice and professional identity. If as Frank suggests, the role of the narrative researcher is to 'bring together voices that are not yet in dialogue (18), then my primary aim here is to contribute to the circulation of these stories and to expand the repertoire of available narrative resources for practitioners, students and educators. This kind of 'joint activity' (Shotter, 2010) or collaborative inquiry, which focuses on the conversations *between* narratives, provides a generative way to investigate everyday meaning of practice. To ground that discussion in the historical and cultural context of healthcare practice, in the next section I explore the legacy of biomedical discourses on contemporary healthcare culture, as well as the more recently emerging 'narrative turn' in healthcare practice and scholarly. Interested in the *in-between*, and often unnoticed, spaces in practice, I will explore how narrative writing constitutes an alternative discourse for practice and education.

4. Narrative in healthcare: noticing the "in-between-ness" of everyday practice

Among many threads in what has come loosely to be termed the medical humanities, perhaps the one that has garnered most attention recently is narrative. At a time when dissatisfaction with medical practice among patients and physicians continues to grow, many have looked in a more rigorous way to the humanities as a source of ideas and inspiration for how to remake the troubled profession.

Rafael Campo, 2005

Most of the time, we demand that our own language prevail…Stories are not merely the product of our experience told through the medium of language. They are also the product of language itself, and depend on the specific language in which they are told.

Albert Manguel[25]

[25] Alberto Manguel is an anthropologist, translator and essayist. This is from *The City of Words* (CBC Massey Lecture Series). Toronto: House of Anansi Press: 58-63.

Overview

In this chapter, I turn my attention to healthcare practice. First, I explore the impact of biomedical discourses on contemporary practice with particular attention to assumptions about objectivity and dualistic/mechanistic views of the body and illness. I then examine narrative approaches to healthcare practice and education which seek to challenge the privileging of biomedical discourses and honour the intersubjective dimensions of clinical practice. This brings us to an examination of narrative reading and writing as strategies to explore the often neglected relational aspects of practice and the everyday experiences of practitioners.

While there are many potential ways to analyze narrative writing by healthcare practitioners, I will consider healthcare narratives in relation to a concept from cultural anthropology – through the lens of liminality. After a brief discussion of the use of liminality as a concept to understand organizational life in healthcare and the experience of illness, I will explore various aspects of day to day practice and professional identity as 'in-between' spaces. In particular, I will examine how narrative writing helps us understand shifting professional identities and borderland spaces in everyday practice; the ambiguous space between knowing and not-knowing, and the role of narrative in confronting uncertainty and ambiguity.

In exploring the personal and professional impact of our practice experiences, practitioner/writers challenge the idea of a detached professional and begin to construct alternative images of practice and professional identity. These images open up rich possibilities for acknowledging the rich dimensions of relationality and mutuality in our work.

The legacy of biomedical discourses: the turn towards narrative

> Medicine, then, like religion, ethnicity, and other key social institutions, is a medium through which the pluralities of social life are expressed and recreated.
>
> Kleinman, 1995: 24

> Narrative medicine is a very practical undertaking. It arises from the day-in, day-out events of the doctor's or nurse's office – right there off the crowded waiting room.
>
> Charon, 2006: 17

Narrative approaches developed partly in response to the perceived limitations of the dominant biomedical model. To fully appreciate the role (or value) of narrative approaches we need to review the implications of the 'scientific method' and western medicine and its major tenets. While a full examination of the history of medicine is beyond the scope of my discussion, I borrow here largely from Engel et al (2008), to identify the major implications of a biomedical paradigm as a way to better situate my discussion on emerging narrative approaches.

Engel et al (2008) acknowledge that within any given historical period there are multiple and often competing idea systems at play. For the purpose of their discussion on 'the making of medicine practice', they bracket the period from the eighteenth through to the early twentieth century to identify the main tenets of the biomedical paradigm which has influenced the development of modern medicine. As they state, paradigms act as "powerful frameworks that influence, both overtly and covertly, how we think about knowledge, discourage competing ideas of what constitutes 'legitimate truth' and become part of an unreflective hold on thoughts and beliefs" and these assumptions "very often operate silently and unreflectively within succeeding generations of biomedical researchers and clinical practice" (Engel et al, 2008: 23-25).

The biomedical model is intimately connected to the rise of scientific paradigms in the seventeenth century (Engel et al, 2008). One of the most significant assumptions of the scientific paradigm is objectivism – the notion of an observable reality that one can 'capture' through detached physical observation and the 'objective' gathering of empirical

information. The rise of contemporary western medicine is characterized by a focus on clinical observation, empirical evidence and the study of pathological anatomy.[26]

Heavily influenced by Descartes, and subsequent Enlightenment thinkers who advanced a mechanistic philosophy, western medicine increasingly adopted the metaphor of the machine to explain the workings of the human body. In this view, the mind is separate from the physical body, and the physical body is regarded purely as a mechanical system comprised of discrete anatomical parts. Illness was thus viewed primarily as a mechanical failing of the body. For example, sixteenth century anatomist William Harvey was the first to describe the heart as a mechanical pump. As Cantor (1995) states, "In contemporary popular scientific portrayals of the body, the 'parts' are often depicted as machine components or elements in an industrial process" (2).

Another significant assumption of contemporary biomedicine is mind-body dualism. The impact of Cartesian dualism on the rise of modern medicine has been well acknowledged and includes an epistemological tradition which emphasizes two different ways of knowing – subjective awareness and direct observation. Within this paradigm, direct visual inspection and autopsy were considered the basis of clinical 'truth' and the "patient's subjective account of illness was dismissed as unreliable and irrelevant to physical diagnosis. In the modern era, another form of dualism continues to exist – that of physician as active knower and patient as passive known" (Engel et al, 2008: 23).

This dualistic and mechanistic paradigm continues to shape notions of what is 'real' (ontology) and what is 'true' (epistemology). This has led to problematic assumptions about hierarchies of knowledge and the undervaluing of 'non-scientific' ways of knowing. Physicians came to view themselves as 'objective' and detached observers of the external world and to regard the object of their observation (i.e., their patients) as unaffected by their own biases. Information that could be objectively observed and verified, through physical examination, and later diagnostic technology, was thus privileged. Ironically and somewhat paradoxically, the 'clinical method' developed in France in the nineteenth century saw a newly emerging interest on 'history-taking' as part of the physical examination. Physicians were trained to rely on their direct observation of physical anatomy as well as the patient's telling of the history and nature of their 'symptoms' as the main criteria for diagnosis and treatment.

The rise of western medicine saw the privileging of basic physical sciences and the 'scientific method' in the understanding of illness and disease processes. This paradigm

---

[26] Interestingly, Engel et al (2008) note that it was development of the stethoscope in the early nineteenth century that began a new era of clinical medicine characterized by a belief in the power of technology to provide information on the body which directly linked symptoms with anatomic pathology (18).

thus saw the physical sciences at the centre of the medical curriculum. Engel et al (2008: 22) describe the powerful effect of scientific discourses on medical education.

> With these reforms, the place of science in medical education and practice was firmly entrenched. Furthermore, being faithful to a prevailing foundational view of knowledge, curriculum developers placed the basic sciences at the earliest stages of medical education. This placement had a powerful effect on the early enculturation of people into the profession.

A biomedical framework which focuses on abstract disease categories cannot do justice to the meanings of an illness or acknowledge the 'full narrative' of the patient. As Engel et al (2008) write, "to put it another way, the Enlightenment legacy of what constitutes legitimate knowledge, namely that which comes through science, serves to *delegitimize* the patient's story and narrative knowledge of the clinical condition" (27). Biophysical information (derived from physical assessment and laboratory tests), are assumed to be 'objective', and the empirical data "screams while information perceived as 'subjective', the patient's illness story (his experience of suffering), is silenced" (16).

The biomedical paradigm has shaped the broad array of health disciplines, including social work, nursing and clinical nutrition. Jacqui Gingras comments on how the privileging of science-based knowledge in nutrition discourse has led to the neglect of the emotional and social dimensions of practice as well as the denial of personal experience as a legitimate knowledge resource for practitioners. Concerned about how scientific discourses have shaped the field of clinical nutrition and contributed to a narrow conception of professional identity by dieticians, she states:

> Dietetic theorists have claimed that dieticians' practice is organized around several key features; it is traditionally structured to privilege science-based epistemologies... these pedagogical and professional contexts have implications for how dieticians do their work, the challenges they face, and the resilience they cultivate in the process. (Gingras and Atkins, 2010: 304)

One of the consequences of biomedical discourses in the health professions has been to obscure the processes by which practitioners are active agents in the construction of meaning in clinical interactions. Students are taught to 'take' histories as a purely information gathering process, rather than acknowledging that they are co-constructing the narrative.

> In fact, in traditional medical education, students are taught to 'take histories' when what they are really doing is 'creating histories'. By turning the patient's complaints into generalizable concepts which can then be categorized explicitly for the purposes of constructing a differential diagnosis, the students make a

> particular patient's experiences the same as for all who have such experiences. (Engel et al, 2008: 25)

In focusing on issues of meaning, cultural anthropologist Arthur Kleinman (1995) has argued that 'meaningful interpretation' lies at the heart of the illness experience and the day-to-day work of healthcare practitioners. While Kathryn Hunter (1993) suggests that clinical medicine shares its methods of 'knowing' more with the social and human sciences, than with the physical sciences, practitioners seldom recognize the largely interpretive nature of their work.

In contrast to professional discourses that aspire to the 'scientific method', Hunter suggests that professional practice can be better viewed as a type of 'moral knowing' or an 'interpretive practical reasoning':

> The notion of interpretation – the discernment of meaning – is a central concern of philosophers and linguists, but it is a concept with which doctors and other scientists are often unfamiliar, and hence uncomfortable... But unlike those disciplines, it does not explicitly recognize its interpretive character or the rules it uses to negotiate meaning... (cited in Greenlaugh & Hurwitz, 1999: 49)

For physician and poet Rafael Campo meaning is central to the practice of medicine. He identifies two main, and often competing, narratives operating in healthcare practice: the 'biomedical narrative' (constructed through physical examination and tests) and the 'illness narrative' (the lived experience of the patient). Not denying the importance of technical competencies (and biomedical data) in arriving at diagnosis and treatment, Campo is troubled by what is typically silenced in the interactions of patients and providers – which narrative is privileged and which is left out.

> I think there are two competing narratives of the body, of suffering: the first is the one that comes from the lived experience of ecstasy or pain... the second is the biomedical narrative, which I construct with biopsy reports, CT scan results, CD4 cell counts and blood pressure measurements. In our current moment, in our rampant fascination with science, this latter "just the facts" narrative claims, arrogantly, to be the more important one, the more valuable one...

While he recognizes that the technical competencies of practitioners are important, he nevertheless suggests that the privileging of the biomedical narrative can obscure important relational dimensions in practice.

> [Our] rampant fascination with science... claims, arrogantly, to be the more important one, the more valuable one – so we remunerate physicians lavishly

> for tests ordered or procedures performed. And yet at the same time, what most patients seem to feel is most lacking in medicine these days is compassion, the sense that their doctors listen to them, that their own unique voices are heard...[27]

Not intending to be 'anti-science', the purpose of the critique of biomedicine is to bring the implicit assumptions of the paradigm into focus, examine the implications of its discourses, and acknowledge its limits in responding to the personal meanings of health and illness. In other words, it is to invite an integration of technical and relational knowledge into healthcare practice. I draw here on Campo's notion of a truly competent practitioner as someone who moves *beyond* their technical competencies to practice in a relationally responsive manner that allows them to receive patients' stories in more meaningful and useful ways.

Narrative approaches to healthcare view stories as central to understanding professional practice as well as a way of understanding the interactions between practitioners and patients/clients. Informed by Kathryn Hunter's (1993) influential work *Doctors Stories*, Nicholas and Gillett (1997: 296) discuss 'story' as a primary metaphor for understanding practice as:

> story forms the basis of medical care in the narratives patients bring to their doctors and in the narrative the doctor constructs in relation to the patient. Story also structures the conversations between health professionals and provides a major vehicle for the transmission of knowledge and the formation of a professional.

While understandings of narrative approaches in healthcare are varied, physician and narrative medicine scholar Rita Charon describes 'narrative healthcare' as the appreciation of the stories of patients and clinicians (Engel et al 2008). Informed by a cross-disciplinary integration of literary studies and narrative theory, a narrative approach to healthcare is a 'new frame' (Charon, 2006: 13) for practice and training, and focuses attention on the relational dimensions of practice. It is medicine practised by someone who knows what to do with stories and has an ability to think with stories (Charon, 2007).

Acknowledging that clinical practice requires the engagement of one person with another, Charon (2006) contends that being able to 'listen for stories' is at the centre of a relational and narrative-informed approach to care. "Listening for stories is what we in healthcare must learn to do. To listen for stories, we have to know, first of all, that there are

---

[27] From *Of Poetry and Medicine: An Interview with Rafael Campo* by Cortney Davis. Accessed 7 November 2012 from www.poets.org/viewmedia.php/prmMID/19160.

stories being told. We have to notice metaphors, images, allusions to other stories"(Charon, 2006: 66).

The ability to think with stories opens up practice – changing what we do with patients, clients, colleagues, students and ourselves by attending to multiple perspectives and the intersubjective realities of our practices. In contrast to conventional discourses that emphasize practitioners' general knowledge, instrumental roles and technical skill, narrative approaches situate practice within a framework that highlights the multiple, and overlapping, relationships in practice (Charon, 2006: 2). In discussing the role of close reading and reflective writing in promoting relationally responsive practitioners, Charon (2006: 195) writes in *The Self Telling Body*:

> Close reading builds the capacity of the reader to achieve the state of attention required for effective clinical work. If, indeed, close reading equips one to adopt alien perspectives and cohere complex narratives toward multiple meanings, these same capacities might improve a clinician's ability to attend to what sick people say and then, one hopes, to act on that teller's behalf…Without writing about the care of a patient in a complex narrative form, the care-giver might not see the patient's illness in its full, textured, emotionally powerful, consequential narrative form. It remains to be proven – although it appears a most compelling hypothesis – that such narrative vision is required in order to offer compassionate and effective care to the sick.

Campo[28] suggests that through narrative methods like poetry reading and writing, patients can reclaim the personal meaning of illness and suffering

> We come to poetry... I think because we are silenced in many ways. In biomedicine, we're so good at appropriating the narrative – the biopsy report, the CT count, the potassium level. Writing gives patients an opportunity to say, this is *my* cancer, this is *my* HIV. It's not a generic, what you see on the mammogram or how many lymph nodes are positive – I'm an individual.

Narrative approaches acknowledge more fully the intimate relationship between professional practice, identity and experience. Charon (2006) suggests that attention to narratives "increase the power of all health professionals to come to grips, through reflection, with what being a caregiver means in their own lives and the lives of their

---

[28] Accessed 12 April 2013 from www.poetryfoundation.org/bio/rafael-campo. In interviews Rafael Campo has called himself "a mutt, a mongrel, a kind of happy monster," referring to the multiple (and sometimes conflicting) professional and personal identities he embodies. A poet and physician, Campo practices internal medicine at Harvard Medical School and the Beth Israel Deaconess Medical Center. Raised Catholic, he is openly gay and devotes much of his practice to treating marginalized populations, including Latinos, gay, lesbian, and transgendered people and those living with HIV.

families" (11). Trisha Greenlaugh comments on the centrality of stories – not only to clinical relationships – but to the construction of professional identity. Recognizing that we tell stories not only about patients, but about ourselves, she states:

> Storytelling enables us to reflect on, uphold and refine our roles as health professionals, especially in relation to critical or significant events... we tend to tell stories about 'difficult' patients and situations, about our professional roles and perceived failures in them, and about contentious relationships within and across professional boundaries. (Greenlaugh, 2001, 818-9)

In her study of occupational therapists in healthcare settings, Cheryl Mattingly (1998) conceptualizes storytelling in day-to-day practice as a kind of 'time map' for practitioners – a way to recount past events, orient themselves to where they currently are and discover where they can go. Telling stories to self, colleagues and patients thus becomes a "way to make sense of what has happened and this makes stories essential to practice" (6).

Narrative approaches root our understanding of day-to-day practice in its inter-subjective dimensions and, I would add, in its language practices. Charon (2006: 53) remarks on the centrality of 'text' and 'textuality' as a defining feature of the relationships between practitioners and patients stating,

> what literary and social studies give medicine is the realization that our intimate [clinical] relationships occur in words. Our intimacy with patients is based predominantly on listening to what they tell us, and our trustworthiness toward them is demonstrated in the seriousness with which we listen to what they entrust to us.

In examining the role of patient stories (or illness narratives) in health professional training, Charon emphasizes that stories build affiliation between those telling and those listening – which can decrease the intensely isolating nature of illness. In discussing the connections between readers and the stories of illness in creating community she states, "the reader (of an illness narrative) is summoned by the author to join with the teller – to form community that can combat the isolation of illness... by virtue of the writing, there is hope for connection, for recognition, for communion" (Charon, 2007: 4).

In the following passage Campo tries to tease out the sometimes intertwined narratives of practitioner and patient – untangling the threads of writing about self and writing to connect with others. While not denying the very different positions that practitioners and patients occupy in clinical situations, he is interested in writing as a way to affirm connection, shared experience and increase empathy.

> Sometimes I discover that I'm really writing about myself, my own arrogance or vulnerability or alienation, and I wonder if what feels like selfishness is at the same time an expression of the familiar wish to identify with another person, to affirm that I'm no different, that I'm equally as flawed and conflicted and needy as any of us is. Illness is, after all, one of the few truly universal human experiences; to write in response to it necessarily demands active participation, not the kind of objective, soulless distancing so many doctors practice, and teach their trainees to practice. To write about illness, to heed this terrible muse, is to reject distancing and to embrace empathy.[29]

The biomedical paradigm, which operates "silently and unreflectively" (Engel et al 2008) on practitioners and patients, has fostered an increasingly impersonal approach to clinical practice. Biomedical discourses create distance from the 'lived experience of the sufferer' and ignore the contextual dimension of health and illness. Challenging the science-driven biotechnical discourses that pervade medical practice and training, Campo suggests that narrative writing can provide a way to navigate through the experience of illness for both patients and practitioners.

Encouraging us to think about what is 'silenced' in clinical settings, he calls attention to what is *'left out'* by an exclusive focus on the biomedical. Campo shares a story about a medical resident that illustrates his concern over what gets omitted.

Story: Tuning out

> I am reminded of one of my residents, who was called to run a code on a patient of hers in the hospital just as she was about to leave for the day and enjoy some time with her young family at home. She had followed all the biomedical protocols and algorithms perfectly, barking orders to the nurses and interns with all the confidence she could muster; however, like most end-of-life interventions in the hospital, this one too proved futile, and the patient died. It was only weeks later, when she had the chance to write about the experience (in a poem she created for a reflective writing group that is now part of the residency curriculum in our hospital) did she feel she could do justice to the entire experience, aspects of which she purposefully had shut out at the bedside in the perceived acuity of the situation. Perhaps most salient of all that she had sacrificed to the biomedical exigencies of the moment was the tuning out of the family who were present in the room; she wished she hadn't ignored them, but instead had allowed them to stop her before a full thirty minutes had passed, when it was already amply clear to them that their mother was dead.[30]

---

[29] Accessed 12 April 2013 from http://poems.com/special_features/prose/essay_campo.php.

[30] Accessed 5 April 2013 from http://blr.med.nyu.edu/content/current/illnessasmuse.

In this story, the resident's sole attention to her immediate clinical obligations, to the exclusion of everything else that was going on in the room, leads her to question her practice. While she has handled the exigencies of the 'biomedical protocols perfectly', it is the 'tuning out' of the family that triggers discomfort and calls for closer attention. She is disquieted by the purposeful shutting out of what was happening at the bedside – ignoring the family – that stays with her and compels her to tell this story.

As a medical educator re-telling a story about a particular incident, Campo is calling our attention to the importance of storytelling. The story allows a fuller picture to emerge. While the details of this story do not make it into the chart, they nevertheless register powerfully on everyone present – both healthcare providers and the family.

> It is precisely situations like these that have so long been cited by medical educators as a primary reason for teaching distancing to medical trainees: to be able to function in an emergency, one cannot regard that patient as a whole person, but rather must focus on the malignant arrhythmia or the life-threatening electrolyte imbalance in order to implement the appropriate technologies and in turn save life at all cost. Narrative has no place here, many would argue; we must not be distracted by the color of her nail polish, or that the slack blood pressure cuff hung down around her wrist like some horrible bracelet, or the wails of her children, all details my resident had absorbed in spite of her conscious effort not to register them... Whether storytelling has a place here is worth considering very deeply; it certainly proved indispensable after the fact... (Campo, 2011).

The story invites us to consider the woman from another perspective – not merely as a patient. A narrative approach requires us to stretch ourselves to take into view our responsibilities to others and more fully acknowledge the impact of our actions (and inactions) on others.

> if we begin to enlarge the context, as narrative asks that we do, if we start to consider that our actions have impact on others who have their own relationship with the person we see exclusively as "a patient" (and not as "a mother," as her children do; not as "a suffering soul," as the chaplain does), we might act differently. We might move to comfort the patient and to protect her dignity in her last minutes on earth; we might seek to console her children as they face a tremendous loss... (Campo 2011).

In looking at the narrative account offered here, it seems that what appears will appear in the chart is not so much inaccurate as incomplete. In this sense, the resident's story calls our attention to what the biomedical narrative excludes. In asking us to consider the value

of storytelling, Campo suggests that it is through the story that the resident does justice to her own experience – as well as offering a way to honour the patient, and the family's loss, in a way that was not possible in the emergency room. In telling this story, he is also suggesting perhaps that the resident's story can act as a reminder to us all about how we can do better in responding to the 'other'.

In training healthcare providers to be sensitive to story, and to the often neglected relational dimensions of practice, Charon (2006) discusses the use of narrative methods such as 'close reading' (of literature), storytelling and reflective narrative writing. The aim of this writing is clearly distinct from writing for academic and professional purposes and calls for students and practitioners to write in ordinary narrative prose about their practice.

> In settings as diverse as ward medicine attending rounds, staff meetings on the adult oncology in-patient service, the AIDS clinic, and home visit programs, we meet with healthcare professionals to read and to write, to attend to and re-present all that occurs in these lives led among the sick. (Charon, 2006: preface)

In using reflective narrative writing as a method to train medical students, Charon employs the 'parallel chart' where students are asked to write narratively and reflexively about patients in ordinary language to enable them to recognize more fully what the patients endure – and to examine explicitly their journeys through medicine. In contrast to the writing they do in medical charts, parallel chart are brief stories, specific ('indexed to particular patients'). Students are encouraged to write in the first person to explore the impact of their personal and cultural locations on their emerging professional identities.

> every day, you write in the hospital chart about each of your patients. You know exactly what to write there and the form in which to write it. You write about your patient's current complaints, the results of the physical exam, laboratory findings, opinions of consultants, and the plan. If your patient dying of prostate cancer reminds you of your grandfather, who died of that disease last summer, and each time you go into the patients room, you weep for your grandfather, you cannot write that in the hospital chart. We will not let you. And yet it has to be written somewhere. You write it in the Parallel Chart. (Charon, 2006: 156)

If narrative is a way to highlight unquestioned stories about the "self and the world" and begin to challenge the "power of the unexamined" (Hirshfield, 1997: 112), then stories are a powerful resource in constructing more relationally responsive practices. In thinking about what often gets 'left out' of the official story, I turn now to an exploration of liminal or in-between spaces as made visible through the writing of healthcare practitioners. Narrative writing opens a space outside the boundary of biomedical discourses, and afford a view of the stuff in the margins – the in-between places of our day-to-day practice.

At the threshold: liminality and the in-between of healthcare practices

A quintessentially liminal space, the beach provokes ideas of margins, exchange and openness. The beach is a site of possibility and unexpected surprise, where anything might wash up, but equally, the beach is unpredictable and often dangerous. It is also a location that defies permanence – its shape is perpetually changing, its inhabitants constantly on the move, a landscape relentlessly in motion.

Brown et al, 2007: 1

It has become quite popular to talk about life on the borders.

Mattingly, 2010: 6

During a narrative medicine workshop that I attended at Columbia University in June 2011, physician and narrative medicine scholar Rita Charon read aloud a story she had written about a brief encounter between herself and a boy in a wheelchair in the hospital elevator on her way to work at a hospital clinic one day. There were no words spoken between them, but in examining the "moral obligation to try and imagine, no matter how imperfect, the world of the other," Charon had asked herself, "I wonder what they are doing here – and what is it like to be them?"

While her story raises important questions about empathy, and our attempts to bridge the "unthinkable alterity of the other" (Jackson, 2012: 9), I am most interested in the way this story calls our attention to those 'silent' places in healthcare institutions where people are either waiting for something or on their way from one place to another. It is this so-called *no man's land* (sic) that I now turn my attention through an exploration of the concept of liminality.

In his influential essay 'Betwixt and Between: The Liminal Period in Rites of Passage' (1987), cultural anthropologist Victor Turner (re)introduced *liminality* in social science discourse. Derived from the Latin 'limen', meaning threshold, Turner (1969) used the concept of liminality to signify transitional state in ritual societies and liminal individuals as "neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremony" (95). In Turner's work, the concept of liminality (or in-between states) refers to a temporary or transitional status, and is closely connected to notions of *marginality* (i.e., individuals occupying the 'edges' of society) as well as inferiority (individuals with little or no social status). In her article 'Writing and the Threshold Life,' poet Jane Hirshfield (1998) writes that in entering this liminal state, a "person leaves behind his or her old identity and dwells in a threshold state of ambiguity, openness and indeterminacy" (203).

While Turner's ideas about liminality referred to a transitional identity states within traditional societies, the idea of being "in-between" or on the "edges" remains a flexible, and evocative, concept in the contemporary social imagination as well as social and cultural theory. The 'spatial turn' in postmodern thought, with its language of 'margins', 'edges' and 'borders', is woven throughout cultural studies, feminist theory, post-modern and narrative analysis (Mattingly, 2010). In his discussion of the concept of "thirdspace" zones in urban landscapes, Edward Sojo (1996) urges us to reconsider the usefulness of spatiality in the human sciences and suggests that spatial metaphors are a powerful way to understand contemporary social life.

In her exploration of liminality and physical spaces, architect Smith similarly emphasizes the meaning of liminality as occupying an in-between or transitional "passage between alternative states... a transitional threshold involves the interrelationship between two phenomena rather than their opposition... liminality or the liminal refers to transitional space; neither one place nor another; neither one discipline nor another; rather a thirdspace in-between."[31]

Feminist and cultural theorists have emphasized the value of everyday stories and (so-called) marginalized knowledge (Speedy, 2000). Such writers evoke a sense of the boundaries, and specifically the *margin*, as a site of possibility. This is what poet Laurie Anne Whitt might be hinting at when she writes "But in the spaces between / ambiguities surface / stories run aground the lines where something else begins."[32]

Whitt's poem echoes bell hooks' (1990) influential essay 'Choosing the Margin as a Space of Radical Openness.' In this essay, hooks conceptualizes marginality as a social space where "new and radical happenings can occur" (31). In exploring the cultural struggles involving race and gender, hooks is concerned with the 'politics of location' and social marginality as a 'profound edge' from which to build resistance to dominant ideologies. In seeing the (social) margins as a site of possibility, hooks (re)visions those 'lived spaces of representation as potentially nurturing places of resistance', as sites of potential creativity and power. As hooks writes, "marginality is the space of resistance. Enter that space. Let us meet there" (152).

While the notion of liminality was introduced into cultural anthropology to refer to temporary transitions in which social identity is redefined, liminality has been used to conceptualize a diverse range of issues in healthcare practice and organizational life. The organizational development literature has used the concept to conceptualize marginal positions in organizations, and has closely linked liminality to notions of ambiguity and uncertainty in organizational life. For example, liminality has been used to understand the status of employees who exist on the margins of an organization due to their temporary employment status as well as individuals who do not have a stable workplace identity as they move across internal and external organizational boundaries.

In this context, "the definition of liminality incorporates instabilities in the social context, the ongoing ambiguity and multiplicity of meanings... it can be thought of as a more longitudinal experience of ambiguity and in-between-ness within a changeful context" (Beech, 2011: 287). As a concept for understanding the negotiation of identity, or "identity

---

[31] Accessed 30 March 2013 from http://limen.mi2.hr/limen1-2001/catherine_smith.html

[32] From the poem *Surrounding Stories* accessed 7 November 2012 from http://limen.mi2.hr/limen2-2001/whitt.html.

work" in organizations, liminality is a useful way of understanding how workplace identities are continually disrupted and renegotiated (Beech, 2011). In this sense, it refers to individuals in uncertain or ambiguous situations where someone is 'not this or that'.

In discussing the relationship of liminality to postmodern theory, Catherine Smith (2001) points out that a concept involving 'blurred' boundaries is, by definition, difficult to pin down. If postmodernism blurs the lines of traditionally accepted conceptions of knowledge, related concepts such as liminality also resist being defined precisely. Thus, notions of liminality, and the closely related concept of marginality, remain 'slippery' concepts that are difficult to define outside of their specific historical and cultural contexts.

Like La Shure (2005) who is interested in applying the concept of liminality to issues of contemporary identity, I emphasize the spatial relationships that the term implies rather than the temporal meanings traditionally associated with the term. As Andrews and Roberts (2012) state, liminality strongly connotes a spatial metaphor (i.e., a boundary or transitional landscape) as well as implying a sense of future possibilities. Directing our attention to the possibilities of those in-between spaces, La Shure (2005) asks "where does that leave liminality? Exactly where it started: betwixt and between. It is not outside of the social structure or on its edges, it is in the cracks within the social structure itself."[33]

While both liminality and marginality are associated with ambiguous meanings (possibility and transformation as well as risk and potential danger), I use these terms 'loosely' in my examination of healthcare practice. Like Mattingly (2010), I am most interested in exploring the notion of the borderland as it relates to day-to-day practice – those "small moments of everyday life... the pervasive largely invisible stuff" (7). While these in-between zones may not be visible on any map, they refer to those ambiguous practices "that bind people together who otherwise wouldn't belong together" (Mattingly, 2010: 7).

In turning our focus to a discussion of liminality in healthcare, the theme of transitional spaces and blurred 'in-between' zones has many resonances. T he field of healthcare humanities itself (involving the integration of the humanities in healthcare practice and education), can be understood as a type of interdisciplinary in-between space – or edgeland[34] – between the humanities and social sciences. We can understand practitioner narratives, in particular, as occupying a cross-disciplinary borderland between social

---

[33] Accessed 7 November 2012 from www.liminality.org/about/whatisliminality/.

[34] Rapport et al (2004: 5) describes healthcare humanities as a type of 'edgeland' that refers to the built landscape found on the outskirts of towns, and between rural and urban areas. The edgelands are often a neglected, but important, part of the landscape for "if we fail to attend to the activity of the interface we forfeit the chance not only to shape that change but also to influence the effects of it on other parts of the environment".

science, autobiography, anthropology and literary studies; or what Denshire (2010) calls the 'intermediate space between art and life'. McKenzie (2007) also suggests that narrative writing doesn't fit easily within existing systems of categorization and thus occupies a uniquely liminal space within scholarly work (21).

Professional training and practice has been conceptualized as a kind of 'sustained' or 'perpetual' liminality (Sibbett, 2004). The concept of liminality has been used to explore the experience of illness and treatment, cancer survivorship and end of life care – and is closely tied to taboo issues which are considered *unspeakable* and *unthinkable* in healthcare practice and training (Blows et al, 2012; McKetchnie, et al 2010; Sibbett & Thompson, 2008).

Braude (2011), for example, writes about palliative care ethics as occupying a liminal space in healthcare practice. Acknowledging that the focus in palliative care on 'care' rather than 'cure' puts it on the "margins of mainstream medicine" (108), she explores the connection between liminality and practice wisdom in establishing an ethics for negotiating the intersubjective boundaries between caregiver and patient.

In their discussion of professional identity development in health professional education, Sibbett and Thompson (2008: 9) emphasize that "difficult" or marginalized issues occupy "problematic liminal spaces" and are characterized by silence and avoidance.

> Such issues are associated with liminality in several ways. One association is that they tend to be inherently liminal because they can relate to culturally taboo, frightening or embarrassing areas and so they may have been marginalised or even neglected due to their difficulty. Examples might include those pertaining to limbo and uncertainty, powerlessness, power, various types of playing, communion and spirituality, embodied experience such as suffering, unboundedness, sex, gender identity and mortality. Even issues that may not be culturally taboo but which are just difficult can still be marginalised in professional development training... the uncertainty such issues can engender when approached also tends to evoke liminality in learners and, indeed, in trainers, perhaps as a form of secondary liminality.

The experience of serious illness and disability can also be viewed as a type of liminal space that calls out for sense-making (Mattingly, 1998). Frank (2004) remarks that a tunnel is an apt metaphor for understanding the experience of patients as it constitutes a "constricting space that makes it difficult to see things in their proper light and talk about what these things mean" (15). In the article 'The In-Between', Silverman (2011) explores his son's adjustment to physical disability through the lens of liminality. He focuses on the "silent and powerful space between nothing and something, the space in which we live most of our lives, but are not adept at articulating. "He describes his son's struggles to adjust as a back

and forth process between ability and (dis)ability – at times being in both locations at once and trying to figure out how to live in both.[35]

Foote et al (2002) examine the position of patients referred for ultrasound – and put on lengthy waiting lists – as a kind of liminality. Once patients have been referred for a diagnostic test like an ultrasound, they enter a kind of unbounded 'in-between' space characterized by indeterminacy, deep uncertainty and invalidation (about their symptoms and possible diagnosis). While their analysis points to the liminal nature of illness itself, they point out that this group of "waiting patients" are relatively invisible, as their current waiting status occurs outside the walls of healthcare institutions and places them beyond the gaze of healthcare professionals.

In *The Paradox of Hope: Journeys through a Clinical Borderland,* Cheryl Mattingly draws on the concept of borders and 'in-between' spaces to deepen an understanding of everyday practices in a large paediatric hospital which she describes as a "quintessential cultural border zone" (11). Interested in the importance of borderlands as a pivotal concept in the contemporary social imagination she writes, "the recognition that social worlds are porous, that boundaries are fluid and contested, and that objects and people are bound together or travel in all manner of unexpected ways continues to inspire our imagination and provoke our attention" (Mattingly, 2010: 6).

Mattingly is interested in the day-to-day activities of healthcare providers, patients and families and views healthcare settings as an important context for the negotiation of meanings surrounding illness and recovery. "It is in this practice-based sense that I am using the term borderland. It designates that flexible space in which healing is carried out, not only by health professionals, but also by patients and families". The metaphor of the border challenges fixed notions of professional practice and encourages us to conceive of day-to-day practice as fluid. This understanding of social life sees people and ideas as interconnected and making meaning in their encounters with each other. As Mattingly (2010) acknowledges, border crossing is a necessary, if risky enterprise in fluid spaces such as healthcare.

There are multiple narratives "performed and embodied" in everyday in healthcare interactions that structure the organization of space and time in healthcare practice (Mattingly, 2010; 54). The implicit assumptions within the biomedical narrative create unspoken expectations or how things *should* unfold in clinical interactions – including the promise of science to cure – which Mattingly refers to as "a shadowy narrative horizon only hinted at by the realities of day-to-day clinical practice" (Mattingly, 55). According to Mattingly, the symbolic power of this master narrative underlies everyday clinical practice

[35] Accessed 7 November 2012 from *limen* http://limen.mi2.hr/limen1-2001/.

and creates a complex dance of possibility and failure for clinicians and patients alike as "their symbolic power rests within a more far-reaching drama of clinical hope that is part of the very development of modern biomedicine" (Mattingly, 2010: 55). In particular, a critical aspect of healthcare encounters is the negotiation of 'hope', which she views as a *practice* rather than an emotion, personal struggle or cultural attitude (6).

Using the term 'clinical border activity' to explore such marginal activities in healthcare, Mattingly examines hope as a contested practice between and among healthcare practitioners, patients and their families. In her ethnographic study of children with serious illness, she focuses on the multiple perceptions surrounding illness, disability, and healing held by family members, clinicians, and the children they care for. In this sense, Mattingly (2010) is interested in both the macro dimensions of social practice (the way discursive regimes are embodied and played out in everyday life) as well as the personal and intimate events of social life.

Ultimately her analysis calls attention to the limitations of a biomedical model as hope emerges as a complex, ambiguous and constantly shifting set of practices. As she states, "hope emerges as a paradoxical temporal practice and a strenuous moral project... thus cultivating a hopeful stance is paradoxical; it involves an ongoing conversation with embittered despair. To hope is to be reminded of what is not and what might never be" (Mattingly, 2010: 3).

Interested in those blurred 'in-between' zones in contemporary healthcare practice, Mattingly (2010) appropriately begins her discussion in a hospital lobby which she views as a pivotal cultural, historical and imaginative space because of its in-between and transient character (9). The lobby is a site of travel (both metaphoric and literal) which embodies complex and ambiguous meanings as a border zone where encounters are fleeting and arbitrary. As a land one passes through, it is attended by experiences of estrangement and displacement (Mattingly, 2010).

Mattingly frames the hospital and, in particular, public spaces like the lobby, as a cultural border zone where "actors find themselves uncertain about what others are up to and struggle to be understood by their interlocutors... interpretive trouble is particularly pernicious in clinical spaces where a great deal is at stake" (2010: 11). Her understanding of the lobby as a transient space – intended to provide a place to rest or stop as you pass through *on your way to somewhere else* – marks it as a place of temporary dwelling with an undefined purpose. Central to her conceptualization of the lobby as a "supremely liminal" space, is the idea of waiting as an in-between state, which we will investigate further in the next section.

> When you are in a lobby, chances are you are waiting... There is a great deal of waiting to be done when caring for the sick, or in being sick yourself. Lobbies

> are supremely liminal spaces. You aren't even visiting yet. You are only waiting for a visit. Lobbies, even when well guarded, don't exactly belong to anyone (a notable no-man's-land). In a hospital, they are familiar frontiers. Everyone passes through them from time to time, unlike its many secret spaces where only a few are allowed to enter. (Mattingly, 2010: 8)

As Mattingly recognizes, the connection between waiting and liminality is an important one, but the concept of liminality can be applied much more broadly to understanding healthcare interactions and practices. The notion of liminality lends itself particularly well to exploring those marginalized or neglected moments in practice – what often remains submerged or invisible in professional discourses of practice. The focus on liminality draws our attention to the borders of practice – those subordinate story-lines that often go unnoticed – and in this sense, it invites us to explore "fleeting but 'moving' moments"(Katz & Shotter, 1996: 924).

A relational dialogical approach to inquiry centres our perspective on those in-between and indeterminate places. It places the focus of attention on what occurs between people, what happens as people move from one place to another as well as how individuals move through (literal and metaphoric) space and occupy various shifting identities. In the next section, we turn to an examination of how practitioners navigate boundaries between personal and professional identities and how narrative writing can ultimately challenge hard divisions between the personal and professional, as well as the roles of provider and patient.

Transitional spaces and shifting identities

Places are fluid, dynamic and multidimensional, yet somehow still have binding and sometimes haunting identities and familiarities running through them as threads of imaginative and material narrative are woven with threads of 'having become' and 'becoming'.

Cloak & Jones[36]

You are not yourself the minute you walk out your door. At the points of passage between home and other territories, we manoeuvre and negotiate in order to maintain our sense of stability. At the edge of the property on which we reside, arrangements have to be made so that we may pass out the front gate safety.

Abrahams[37]

[36] Cloak & Jones, 2001: 652.

[37] Abrahams, 2001: 135.

In an interview on the writing of *NW*, Zadie Smith comments that novels "like to convince us that we are cohesive consistent personalities and we judge ourselves according to how consistent we are". Challenging the notion of a unified cohesive identity, she states, "We like to think of ourselves as seamless consistent beings, but when we're not with other people and have a specific [relational] context for the interaction, like I'm her friend, or I'm his daughter, who are we really?" Contesting the idea of a consistent stable 'self' and a coherent seamless life narrative, the entire novel is written in "fragments, flashes" and multiple voices.[38]

While there is considerable literature on understandings of 'self' and 'identity' in narrative and constructionist scholarship, there is general agreement that identity is multidimensional, dynamic and situated within a particular time and place. Burr (2003) points out while the meanings carried by language are never fixed – "always open to question, always contestable, always temporary – so too is the social constructionist view of identity" (53). Firmly rooting individual identity within a multitude of available cultural discourses she suggests that

> A person's identity is achieved by a subtle interweaving of many different threads. There is the thread of age, for example, that of class, depending on their occupation, income and level of education; ethnicity; gender; sexual orientation and so on. All these, and many more, are woven together to produce the fabric of a person's identity... (Burr, 2003: 34)

Commenting on the close relationship between language processes and the notion of identity in constructionist thinking, Harlene Anderson (2001) writes that "from a linguistic and social construction perspective, self (and other) is a created concept, a created narrative, linguistically constructed and existing in dialogue and in relationship" (2). In this view, the self is constituted by a dialogical-narrative identity. Identity is thus seen as an ongoing project, as we embed and create many 'potential selves' in our relationships and interactions with others.

Within this framework, identity does not originate from the inside, but is embedded in the social realm where people "swim in a sea of language and other signs" – a sea that is invisible to us because it is the very medium of our existence as social beings (Burr, 2003: 107-109). Contrary to modernist notions of the 'self' as a fixed, unified or stable essence, a narrative approach focuses on multiple, fragmentary and shifting *identities* (or storied selves). Rather than viewing the self as the inherent property of a stable and fixed individual, the narrative self is viewed as performative and constituted through storytelling

---

[38] Interviewed 7 October 2012. Accessed 5 April 2013 from www.cbc.ca/writersandcompany/episode/2012/10/07/zadie-smith-interview/.

in and through time (Smith & Sparkes: 7). As Anderson writes, "the self is an ongoing autobiography" (1997: 210-215). Thus the narrative self is not viewed as a reflection of a coherent autobiographical self, but rather how 'multiple selves' negotiate diverse contexts and situations. If the stories we tell about ourselves (and others) change over time, then the "performance" of such narratives are opportunities to create possibilities for new identities and actions (Squire in Andrew et al, 2007: 104).

This perspective is echoed in Gergen's (2009) ideas about the "multi-being." "[E]ach relationship," he suggests, "will bring me into being as a certain sort of person" (136). If we "carry the residues of multiple relationships" with us, this gives us many more resources to draw on and multiple possibilities for future actions. "For the multi-being, coherence and integration may be valued, but only within particular relationships. Celebrated as the myriad potentials for effective co-action across a broad and disparate field of relationships" (Gergen, 2009: 138).

Rather than the unitary sense of self characterizing modernist understandings (this is who I am and this is *all* that I am), practitioners' reflective writings speak to the multiple, shifting (and overlapping) identities that we occupy in our professional and personal lives. Informed by the idea that physical spaces are 'contested arenas' in healthcare institutions (Wilkinson 2008), writers explore different kinds of liminal spaces, turning their attention to how healthcare providers 'embody' their professional identities as they move in and out of their professional lives and work spaces.

In her article 'The artist as surgical ethnographer: participant observers outside the social sciences', medical anthropologist Anne Harris (2008) explores the notion of liminality in the negotiation of personal and professional identities. Interested in how visual art and literature can be 'read' as alternative forms of ethnographic research on practice, she turns to narrative as a rich source of 'data' on day-to-day practice.

Harris reflects on the 'embodied' professional identities of healthcare providers through Ian McEwan's novel *Saturday.* about a day in the life of neurosurgeon Henry Perowne. Challenging clear distinctions between fact and fiction, Harris illuminates how practitioners enact and negotiate their professional identity both inside and outside of the hospital – where this identity becomes 'ambiguous and negotiated in alternate ways':

> when accosted by an aggressive man in the street Perowne, close to being violently assaulted, recognizes that his assailant is suffering a neurological condition, as 'a textbook phrase comes to Henry in much the same way as the cantata melody – a modest rise in his adrenaline level... making him unusually associative.' (McEwan cited in Harris: 509)

According to Harris, Perowne then begins to use his medical knowledge to escape the dangerous situation he finds himself in, this power differential being ultimately reversed in the dramatic conclusion of the novel. Ian McEwan has the luxury of being able to extend his character's life into the world of the imaginary, although the postmodern critique of ethnography as ultimately 'fictional' or 'literary' work dissolves this clear distinction between fiction and non-fiction. McEwan's attention to how a surgeon embodies his profession both inside and outside the hospital contributes to understanding the professional identities of practitioners (Harris, 2008: 509).

In her memoir, *The Making of a Nurse* (2007), nurse/writer Tilda Shalof recounts a conversation early in her career between herself and a nurse manager at the end of a gruelling shift in the Intensive Care Unit. Feeling exhausted and not sure how she can go on in nursing, a nursing manager tells her, "You have to learn how to get in and how to get out" (94). In her book *My Nurse's Story* (2005), Shalof[39] reflects on the issue of 'how to get in and how to get out' – what medical anthropologist Harris (2008) refers to as those often overlooked 'mundane details' of day-to-day life.

Shalof's reflections on those daily rituals marking her transition from work to home at the end of her hospital shifts. Echoing Connelly & Clandinin's (1999) observation that the landscape of day-to-day practice involves the crossing of multiple borders involving time and space (103), Shalof identities the often overlooked small daily acts that mark this transitory space and establish the temporal and spatial boundaries that signal the end of her nursing identity and the beginning of her journey from 'Planet ICU to Planet Earth'.

Story: Planet ICU (excerpt)

> Sometimes it is only the clock that frees me at the end of my shift; it allows me to put a limit, or a boundary, around my caring. Without it, I might not know how to stop... I fell into my reliable ritual that liberates me from Planet ICU. I start by swinging my now empty lunch bag as I call out goodbye to my friends. I trudge up the stairs to the locker room, always at a slower pace than when I started the shift and tripped down those same stairs long ago, that morning. I hang up my stethoscope and lab coat in my locker. Bundle up my dirty uniform and bang the locker door shut with my foot. Glance in the mirror over the sink as I sail past. Waiting for the elevator, I think about dinner... I push the revolving hospital door and inhale the city air as I step back out onto Planet Earth. By the time I'm on the subway, riding home, I have begun to reacquaint myself with thoughts of my own family. (Shalof, 2005: 142)

---

[39] Tilda Shaloff is a long-time ICU nurse, patient advocate and author of several books chronicling her personal and professional challenges. See http://nursetilda.com/about.

This is closely echoed in nurse Lianne Mercer's piece "Night Walker" in which she describes leaving the psychiatric intensive care unit and entering the anonymous but alive world outside the hospital. Leaving behind "restless minds and sad hands" her piece evokes a sense of being enveloped into the anonymous and indifferent night, filled with secrets, and an elusive search for hope. "Outside, no one knows my name. I become a tree, listen for sounds of footsteps... A mockingbird sings an elusive song to souls stalking hope. The night licks its fur and yawns, but its eyes never close" (Davis and Schaefer, 1995).

Looking at transitional spaces between work and home brings to mind the poem "Events of the day" written by physician Michael Wynn.[40] This poem evokes both the impact of a 'typical' day and the things that mark the transition away from work; in this case a cup of coffee and a drive home past fields of daffodils. Wynn evokes the sometimes startling juxtaposition of everyday details of clinical practice (evasive symptoms, diagnosis, difficult disclosures) with the life changing conversations that occur. He evokes a sense of his own humility in the face of such (extra)ordinary realities and a sense of what it feels like to leave at the end of the day.

Poem: Events of the day

Tomorrow I will tell Mr. Smith,
who is compulsively tidy,
that he has Parkinson's disease,
and say "epilepsy" to Mr. Alexander,
the 27-year-old trucker
who might have to pull over at 28,
before I listen to Ms. Jones
describe her headaches, memory loss,
and insomnia which, if truth be told,
as it sometimes is in medicine, stem
from the abuse she suffered
before she was twelve.
A lunch of humble pie – a fortunate familiarity
followed by more patient stories
each ornamented with symptoms
like the altar of a baroque chapel.

[40] Accessed 5 April 2013 from http://hektoeninternational.org/Vol3Iss3-Poetry-MichaelWynn.html.

Before my drive home
past fields of daffodils,
their irrational yellow celebrating
renewable discovery, an afternoon cup
(dopamine would help) at the café
filled with people blind to their beauty.

The image of the author driving away from these weighty conversations in his interactions with patients past "fields of daffodils" speaks to the importance of these transitional times and spaces between work and home. Even while sitting in the café, Wynn carries his experience as a physician and remarks on the people there (seemingly) unaware of these other realities – blind to the beauty of the daffodils and, perhaps, their own lives. The imagery of Stein's poem evoked in me a visceral sense of leaving at the end of the day and the in-between places where we still carry an embodied sense of our professional identity. I wrote this account of leaving work one day in 'between work and home'.

Poem: The ride

Leaving the hospital
where people suffer in various ways
I ride my bike towards home
Glad to be released into the evening air
Free of the stories of the day
I ride by a woman pushing a cart
looking disoriented
I have an urge to stop – to help
But I keep on going
Her face receding, becoming a blur
As I continue towards home
My other life waiting.

Also interested in the exploration of professional identity, Howard Stein seeks to explore more fully the intersubjective meanings of healthcare practice through poetry. In his piece "Badges" (2007: 19) Stein reflects on the taken-for-granted practice of wearing badges as a form of "identity, identification and boundary marking" (19). Intending his poetic reflection less as 'deconstruction' and more as 'evocation' on the intersubjective meanings of organizational culture, he writes:

Poem: Badges

We wear badges at work
So that others will know
Who we are and that we belong here
And that we are of no danger to anyone.
Eventually we come to wear
Badges at work to remind ourselves
Who we are and that we belong here
And that we are one of the good people.
We put our badges on before we arrive
And panic when we have forgotten
Where we put them at home or in the car.
We feel naked, vulnerable. We might be
Mistaken for the enemy – or begin to doubt
How harmless we really are.

Inviting us to look differently at the everyday practice of badges as markers of identity, here Stein explores the loss of identity and sense of dislocation that comes with misplacing one's badge. I was drawn to the idea, suggested in Stein's poem, that badges are powerful markers of our professional identities, signifying a sense of belonging as well as marking our separation from others. I was particularly struck with Stein's suggestion that even the temporary misplacement of our identification badges can evoke a sense of disorientation and fleeting loss of identity.

Affirming Charon's (2006) point that when healthcare professionals write reflectively about their practice they learn how interwoven are stories of patients and stories of self, I am reminded of a story from Rafael Campo's early days as a physician. Profoundly ambivalent about his own identity as a gay Latino physician during the AIDS crisis of the 1980s, he comments on his need to distance himself from HIV patients. Reflecting on a visit with one of his patients he recalls using his professional role and ID as a 'protective shield' stating "I cagily read over his chart, displaying my medical ID prominently on my jacket almost as a shield, going so far as to lay my stethoscope out on the desk where I read, lest anyone mistake whose side I was on" (Campo, 1997: 133).

This discussion has focused on those transitory spaces between personal identity and professional practice, and in the next section I turn my attention to another kind of liminal experience in healthcare – acts of "waiting" and indeterminate zones like corridors where seemingly 'nothing happens'.

Waiting and other indeterminate zones

I function like the autobiographer and memoirist, by pulling the past forward, by working to collect images, fragments, and splinters into coherence, by peering into cracks and crevices, into dark shadows.

Ronald Pelias, 2011: 11

In thinking about public spaces and transitional places, the poem "Together and waiting" by Daniel Thomas Moran[41] evokes the strange sense of being both alone and with others while in hospital waiting areas. Drawing our attention to details (like noticing the paper flowers on the wall, and hearing other people's names called), the author suggests that people are not only waiting to leave, but are anxiously waiting to return to the ordinariness of their day-to-day lives. Such spaces are boundary spaces – places intended to be temporary where "leaving there, after all, is the primary point" (Mattingly, 2010: 8).

Poem: Together and waiting

The people in the waiting room at the hospital
cannot help but wonder just what is wrong
with everyone else.
The old woman in the borrowed wheelchair.
The man with the bandaged right hand.
The brown child whose mother is crying.
Someone has taped paper flowers to the wall.
A person in a green outfit will come for them soon.
They will learn, one at a time, the names of
The old woman in the borrowed wheelchair.
The man with the bandaged right hand.
The brown child whose mother is crying.
They all just want to be OK,
for the person in the green outfit to tell them so.
Then they can be happy again, happy
to be gone from the waiting room at the hospital.

And they can forget the colors of the paper flowers taped to the wall
and the names they had learned one at a time.

Amplifying this sense of waiting areas as borderlands, social worker Rita Wilder Craig (2007) writes in "A Day in the Life of a Social Worker" about the hidden dramas that unfold as patients occupy the indeterminate zone of a hospital waiting area. This clinic waiting room, where officially 'nothing happens', is truly a no man's land (sic) – a place where

[41] Accessed 5 April 2013 from http://mh.bmj.com/content/38/1/37.extract.

patients and families wait under chaotic conditions for treatment. It is here where the mundane reality of waiting comes up against the realities of illness. She writes,

> the Outpatient Oncology often looks like a war zone and today is no exception... The decor is dreary and there are often not enough chairs for the patients and family members who come with them. Some are standing. This is difficult as a lot of waiting goes on in this clinic. It is often an all-day affair. They even serve lunch here, although most people don't feel much like eating. (Wilder Craig, 2007: 439)

Interested in exploring ideas about transitions, identity and public spaces in healthcare practice, I wrote the following poem as a way to respond to the idea of waiting in the previous poems. My writing is informed by Mattingly's notion that public places in hospitals are "supremely liminal spaces", Wynn's poetic account of leaving at the end of the day, Stein's reflections on badges as markers of identity and Moran's account of patients waiting. Wanting to explore the "dubious interspaces" (Whitt, 2001) of healthcare practice, I wrote about the daily routine of entering the hospital.

Poem: Hospital Corridor

entering the day-surgery hallway
the memory of cool outside air still on my face,
rows of people in blue gowns
line the corridor to my left and right,
Waiting.
They look up as I pass,
their expectant eyes on me
waiting for something to happen
or for news, but I have nothing to offer them
as I rummage in my bag for my ID
I keep walking, not meeting their gaze
their disappointment following me –
I have let them down.

Locating my badge (I feel the panic subsiding)
and hang it around my neck,
like a talisman, or a shield (I'm not sure which)
I am ready for another day.
Identity intact.

My purpose, in this poem, is to evoke a sense of in-between places – physical areas like this hallway which is both a waiting area for patients and their families and a corridor through which many staff pass en route to offices. As a passage way for staff, this corridor is neither here nor there – a place where seemingly 'nothing happens'. For patients the area is also a no man's land as they sit, stripped of their clothes and swaddled in green hospital gowns, waiting to be called for treatment. It is a place where family members and friends wait (some more), looking at turns expectant, bored, and worried once patients disappear through the swinging doors of the day surgery clinic and operating theatre.

The corridor is a highly 'ambivalent' space as patients occupy a liminal state characterized mainly by waiting which is "endemic to patient life" (Mattingly, 1998: 59). Yet the same corridor also marks a place of transition for me as I begin my day as a social worker and educator. Echoing the idea that hospitals can be experienced as "distorted corridors" (Frank, 2004: 15), this poem is a reminder of another kind of ambiguous place – one characterized by the uncertainty and anxiety associated with illness, disability and suffering. This poem is also a reminder of my own relationship to the "kingdoms of the sick and the well"[42] and echoes Frank's terms *guests* (to describe those needing care) and *hosts* (those in a position to offer care). Frank's conceptualization explicitly acknowledges how temporary and shifting these positions are.

In this sense, the poem is an acknowledgement of both my separation *and* connection to the people lining the hallways, and the ways in which I construct my identity as a practitioner anew each day. While walking through this hallway is part of my daily routine, for patients waiting for surgery, it is likely a combination of the mundane and profound which often travel side by side in healthcare settings (Mattingly, 2010). On the idea of hospital spaces as 'neither here nor there', Mattingly (1998) states, "there is an unruly, ungoverned quality to time, as well, particularly from the patient's perspective. For all this chaos, there is also plenty of waiting and no clear sense that moving is taking anyone anywhere" (63).

When I wrote the lines "They look up as I pass / their expectant eyes on me/ waiting for something to happen / or for news / but I have nothing to offer them", my hope was to evoke a sense of expectation, anticipation and disappointment, as I am not able to provide them with anything useful. This poem is an attempt to see myself as hospital "guests" may see me. As educator Stephen Brookfield (2008) comments "seeing oneself through our

[42] I borrow here from Susan Sontag's (1978) influential ideas on the experience of illness: "Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place".

patients' eyes constitutes one of the most consistently surprising elements in any clinician's career. Each time we do this we learn something" (70).

I am struck by the creative ways that other practitioners evoke this 'hall of mirrors' through their poetic writing – a self-reflexive looking at oneself, trying to imagine how others might see us. Evoking the image of practice as a "mirrored room" which reflects back what is said within it (Hare Mustin, 1994), nurse/writer Stacy Nigliazzo explores tensions between how we see ourselves and how our patients/clients may see us in her poem 'Chirality.'[43] Building on the idea that the quality of some objects cannot be superimposed upon their mirror image, Nigliazzo describes the intention of her poem:

> In an emergency setting, the interventions provided by nurses are often harsh by nature... Other times, there is nothing that can be done except to provide comfort as a patient deteriorates. This poem is a personal exploration of the difficulty and responsibility of this role, as well as an attempt to catch a glimpse of my patients' perceptions of me as a nurse and my own perceptions of myself.

Poem: Chirality

I see myself, always
through a stark looking glass
the fun house view of my own face
reflected in the eyes of my patients

tangled in the bleeding strands
that line the gray schlera of the meth addict

drowning in the pooling ink that splits
the swelling pupil of the hemorrhagic stroke
swimming in the antibiotic slather
that blurs the newborn's first gaze

my clouded countenance
ever present

slipping even through parched flesh
along the steely glide of the angiocath
glistening in the fluid bag
of intravenous medication
glaring back

---

[43] Accessed 28 March 2013 from www.pulsemagazine.org/Archive_Index.cfm?content_id=140.

from the sliding metal siderail

twelve hours streaming from my skin
like an open wound in the scrub sink

face to face
in the soap-splattered mirror

only then,
do I look away.

In this poem, we glimpse a nurse looking at herself ("I see myself through a stark looking glass") as well as her imagining how her patients might see her ("my own face reflected in the eyes of my patients"). She sees herself "in all the mirrors of other people's consciousness" and "in all the possible refractions of one another's perceptions" (Frank, 2004: 44) glaring back at herself through all the various injuries, illnesses, and medical technologies used by her patients. The poem can be read as an attempt to advance a dialogical ethic that "calls us to imagine what we look like – acting as we are – to the people around us, and grant those perceptions equal validity" (45).

In his discussion about family therapy, Frank (2004) suggests that reflective practices may offer a 'mirror' in which families (and therapists) see their lives reflected in a "new language with new images and expand people's sense of who they are and who they could be" (8). Drawing from this idea, it strikes me that evocative writing, such as the poem 'Chirality', are a powerful kind of reflective practice that offers readers new images of not only who we are, but who we could be.

The poem "In Line at the Hospital Coffee Stand"[44] by physician Tabor Flickinger evokes a different kind of in-between space in healthcare institutions. In making explicit the close connection between her professional identity and her ability to write reflectively about her practice, she describes herself as "a poet who believes that the appreciative insight of her clinical work makes her a better writer and that the reflective process of her creative life makes her a better doctor".

Poem: In Line at the Hospital Coffee Stand

At the coffee stand as always getting tea,
so always that the ladies see my weary face

[44] Accessed 5 April 2013 from http://pulsemagazine.org/Archive_Index.cfm?content_id=242.

and start the water steaming without words.

I hover there with others waiting think through labs to check
imaging to glance at does he have pneumonia or pulmonary edema
has social work found her a nursing home will his family want a feeding
tube despite his end-stage dementia did I order cytology on that peritoneal
fluid when will I next see the sun it's so

"Oh, did you take care of him before? He's dead."

unnatural in here fluorescent
now where was I peritoneal fluid hey I wonder who is dead

"Yes, I heard. We all had him at some point.
He was in the hospital every few weeks for his heart and renal
failure. What happened?"

"He didn't want to suffer anymore. Had us turn off his defibrillator.
Stop dialysis. Arrhythmia. Likely hyperkalemia."

I know the man they mean without names.
I took care of him before. He's dead.

His heart pumped ten percent it couldn't keep fluid out
of his lungs and felt like drowning sometimes better after
dialysis but he hated the fistula in the arm that got infected
so sick all the time I guess he couldn't take it anymore
no quality

Tea is ready. Over to the cream and sugar shelf.

of life and it's a relief really for him
and so many who tried to help but the gathering dark
could not be stopped

In reflecting on this poem, the author states: "I wrote 'In Line' in response to an experience that I had in the hospital, overhearing a conversation about the death of a patient whom I had cared for in the past. I was occupied with my routine tasks for the day when this event disrupted my rhythm. I wanted to honor who this patient was as a person and the difficult struggle that his life had been."

In this sense the poem expresses the sense of dislocation that can occur at any time in the hospital and acts as a kind of reflective pause – or interruption to one's routine. From a review of her upcoming tasks involving a series of other (anonymous) patients, she is 'moved to stillness' (Lockford, 2002: 76) in hearing the news about this particular patient.

Below is my poem inspired by Flickinger's powerful rendition of the experience of hearing something that cuts through the 'mundaneness' of our day-to-day routine, and calls attention to the 'background noise' that we soon learn to forget.

Poem: Interruption

This reminds me of times sitting in a meeting,
chatting in the coffee line, or laughing in the hallway
just going about our usual business,
when we are interrupted by a 'code red'
the disembodied voice coming from
nowhere and everywhere
out of the loudspeakers
filling up all the empty spaces
I am caught off guard, hoping that
someone responds quickly,
as they repeat it two and three times
sometimes this sense of urgency
(or is it dread?) stops our discussion cold
momentarily disoriented, as we pause
for just a second under the unnatural lights,
not sure if it's OK to go on.
Other times we just continue
pretending not to hear
as if something momentous
isn't happening
as we continue speaking
going on with our business.

Both Flickinger's poem and mine echo the themes Frank discusses in an article in which he suggests that reflection starts the 'interruption of the routines and rhythm' (the 'temporal flow') of our daily life (Frank in Kinsella, 2012). The poems themselves are a form

of reflective practice – a response to Frank's call for a 'reflective pause' to help us move from abstract generalization to the particulars of the individual.

Another kind of liminal space in healthcare is the shifting personal and professional roles practitioners potentially inhabit. The crossing of personal and professional lines is addressed in different ways by writers who explore the experience of transitioning from 'professional' to 'patient'. Overall, they acknowledge that these are not permanent or stable states, but rather temporary roles and 'performances'.

Nurse Mary Jane Nealon talks about the moment in her nursing training when the conventional boundary between herself and her patients dissolved. Hearing about her brother's illness she says, "I knew at that moment my entire life was changing. I was holding a clipboard and little index cards with lists of medicines. I remember looking down the hall, seeing all the doorways, and understanding how each room had a story like mine. Some bad news had come on a beautiful day and changed everything for them, too. I felt connected to all the people in those rooms. Comrades." (in Schaefer, 110).

In her article 'An Inquiry into Mindful Caring' (2008), Rosalie Dwyer Kent speaks in a powerful voice embodying the 'double vision' (Schaefer 36), or multiple perspectives, of nurse, researcher and patient. From that vantage point, she notices the often taken-for-granted institutional practices that objectify both patients and healthcare providers. As part of her reflection she includes her piece "Down the Hall" which she describes as a "poetic representation of a difficult experience," she invites readers to identify with her experience, as she describes what it's like to be a day surgery patient. Interested in the tensions institutional and personal narratives that affect patient care, Kent takes us with her as she begins the "long, somewhat mundane, but poignant journey down the hall" (42).

Poem: Down the hall (excerpt)

a long slow walk
down the hall
checking room numbers
a short distance in fact
and midway along the hall
a wooden box on an old desk
with an ominous sign above
in large print
outside room 403
PLACE YOUR PAPERS IN THE BOX AND WAIT.

sitting
waiting
speaking in hushed tones
befitting the sacred
in human affairs
almost prayerful
and not unusual in retrospect
our mortality
submerged consciousness
perhaps a bravado sustains us
as each experience
in surgical daycare
unravels a personal journey

now it is my turn
I follow my nurse
after making eye contact
a simple gesture
but separation
distance
is the order of the day
We are going to room 408

Interested in the 'anonymous' patients and 'no-name' clinicians, Kent views the patient role as 'stark and severe', and the nursing role as 'scripted and contractual'. From her perspective as a surgical patient the nurses seem like "technicians completing care and checklists framed within set time and places laid down in the journey script that is critical for entry to the theatre" (55). In Kent's reflections on her healthcare experiences, the dominant script of efficiency, technical competence and task completion undermines interpersonal caring as it reduces interactions with patients to the 'bare essentials of communication' (47) and renders both patients and practitioners without a voice.

In this sense, she argues that nurses are part of an increasingly narrow and '*marginalized story*' that renders their clinical roles and professional identities increasingly disembodied and depersonalized. From her multi-storied perspective as a "person who is a patient and a nurse teacher" (61) she calls our attention to what practice might look like when we are not mindful of the importance of caring practices.

Discussing the 'personal identity theft' that occurs as patients are processed like 'numbers in the cue', she asks, "what is the nursing story and are nurses also experiencing a kind of identity theft as professional parameters shift in a business model of health care... What stories would nurses in this situation tell us about who they are and what their practice lives are about?"(Kent, 2008: 51). Viewing nurses as skilled technicians with "muted voices" she cautions that their interactions with patients are like a fixed script – "silent and impersonal" (51).

Alternating between first person/narrative voice and a more academic voice, Kent provides a rich and nuanced account of her experience as a patient, seen through the lens of a nurse and educator. Interested in how personal and professional stories of the experience of illness can help learners and practitioners find meaning in their professional contexts, Kent wonders about the "disembodied and institutionalized template story" shaping these interactions, asking "what accounts would we hear from the nurses, attendants and doctors on their experiences of preparing patients for the operating theatre?" (2008: 52). She invites us to consider how we can be more mindful of 'caring practices' in clinical settings and build more collaborative accounts of practice from the perspectives of both patients and healthcare providers.

In the following short story "Are You a Doctor?"[45] theology professor Margaret Kim Peterson expresses the thin (and sometimes elusive) line between personal and professional roles in a different way. In this story, we see the fluidity of roles as a spouse assumes the role of caregiver and professional 'expert' in trying to negotiate better care for her husband.

Story: Are You a Doctor?

"Are you a doctor?"

I am sitting by my husband's hospital bed in the surgical admission ward, where he is being prepped for surgery to close a severe pressure ulcer on his left ischium, the knob on the pelvis where your weight rests when you sit.

Dwight was eighteen when an illness damaged his spinal cord, rendering him a paraplegic. He is 49 now, and developing the kinds of problems that go along with being a middle-aged cripple (his self-descriptor of choice).

One such problem is pressure ulcers. We thought we'd learned how to manage these, but met our match in this one, which has refused to heal no matter what we've done. Finally Dwight has agreed to surgery, and to the months of post-operative hospitalization that will follow.

---

[45] From www.pulsemagazine.org/archive_index.cfm?content_id=194. Accessed 27 March 2013.

So here we are in surgical admissions, talking with the anesthesiologist.

"You're anemic, so you'll need to be transfused before surgery," she tells Dwight. "The surgeon has ordered two units of packed red blood cells."

"What?" Dwight asks, through a fog of preoperative anxiety.

"Packed red blood cells," I say. "As opposed to whole blood."

Packed red blood cells are cells that have been separated from whole blood for transfusion purposes. My knowledge of the distinction seems to startle the anesthesiologist.

"Are you a doctor?" she asks.
"No," I say. Then, feeling that perhaps courtesy requires some explanation, I offer one.

"My first husband died of AIDS. He was transfused a lot."

Now she really looks startled.

"When did he die?"

"Fifteen years ago. The fall of 1995. It was the peak of the AIDS epidemic in the United States. Protease inhibitors were introduced a month or two after his death. It's a different world now."

"Yes." The anesthesiologist looks like she might like to ask more questions, but there's no time. She fades away into the farther reaches of the hospital, and I never see her again.

Classes begin the next day at the college where Dwight teaches New Testament and I teach theology. In my first class I introduce the syllabus, call the roll, invite my students to introduce themselves and then introduce myself to them.

As always, I mention my first husband, and the fact that he died of AIDS. I know that AIDS has touched the lives of many of these young people, and that often they don't feel free to make that fact public. I see it as part of my job to set a counter-example.

"A couple of years later I married the other Dr. Peterson," I continue. "I know, I know.

Another guy with something wrong with him."

My students freeze. Are they allowed to respond?

"Sometime we'll have to talk about it," I say with a smile. The room relaxes; the students smile back at me and at one another.

A week later I get an email from a friend, inquiring about Dwight and the progress of his recovery. I write back, saying that the surgical site is healing, but the medical picture as a whole is complex. "The IV antibiotics are causing a lot of GI problems, his protein levels are really low, so is (or was) his hemoglobin (they gave him two units of packed red blood cells before surgery, and another two on Saturday), his electrolytes are out of balance because of everything else, etc."

My friend writes back: "You sound like a doctor!"

Another week goes by. Dwight is transferred to a long-term acute care hospital. His feet are swollen, and so his surgeon has recommended that we bring in the pressure boots Dwight wears at home. A nurse asks what we've been taught concerning their use. We haven't been taught anything, we say, but at home Dwight wears them a few hours a day.

"When he's in the hospital, he should wear them all the time," the nurse says authoritatively. "We'll put them on and check his feet four times a day."

Three days later I happen to glance at the boots. Idly, I ask Dwight, "When was the last time they checked your feet?"

"No one has checked my feet," he says.

My heart sinks. I unzip the boots.

Dwight's feet are covered in blisters. I feel a flicker of anger, and another of fear. Why didn't Dwight make sure someone checked his feet? Why didn't I? How bad is the damage?

Within minutes there are two nurses in the room, silent, shocked, removing the boots, charting the blisters, while I vent between clenched teeth to Dwight about all the doctors who have rounded on him in the past few days, not one of whom bothered to notice the boots or check his feet.

The doctors make a convenient target. It's easier to be angry with doctors I've never met than with nurses I know, or with Dwight, or with myself. And it's easier to be angry with these unknown doctors than to open myself to how overwhelmed I feel. I don't like being in the midst of a medical crisis; I don't like not knowing whether Dwight will ever get well; I don't like feeling that it's up to me to keep track of all the details, and that I'm failing.

I've learned to talk "like a doctor" precisely because it has helped me keep track of details that can make the difference between health and illness, even life and death. But right now, looking at those blisters on Dwight's feet, all I want is for someone else to be in charge, someone who actually is a doctor –someone whose mastery of medical language is complete, who never lets any detail slip through the cracks, who prevents all problems before they happen. Isn't this what a doctor is supposed to do?

For the moment I conveniently forget that no doctor, no matter how good, can keep the dangers and vulnerabilities of life in the body at bay forever. Right now, I'm just angry.

I'm also late to pick up our ten-year-old son from school. Before I leave, I take a deep breath, put on my best professional non-reactivity and talk with a hospital administrator about what has happened, and what needs to change.

Am I a doctor?

No, I'm not a doctor.

This piece beautifully evokes the intersecting of personal and professional selves and "just how fluid, mutable, and ultimately interchangeable our roles can be: how, in a mere moment, one can transform into the other" (Shalof in Nisker, 2008). While many narratives by healthcare practitioners address what it's like to cross over to the 'other side' as they

address 'what it means' to be a patient or family member[46], Peterson's story illustrates a different kind of 'crossing over'. This piece collapses the sometimes deep divide between our personal and professional selves as the author navigates her way through her husband's illness and the complexities of his medical treatment based on her previous experiences of family illness and caregiving.

The story strikes me as significant as it explores the often unrecognized territory of how patients and their families begin to accumulate 'expert' knowledge and shift into the discourse of healthcare practitioners. Aptly titled "Are you a doctor?", it is the author's unexpected familiarity with the 'code language of medicalese' (Campo, 2004) – albeit limited and imperfect – that signals a shift in her relationship with the healthcare providers. In acknowledging that it is largely language that signals our membership in a particular (professional) group, the author defines a "doctor" as someone "whose mastery of the medical language is complete".

In reflecting on her professional role as a professor of theology, we also get a glimpse of another kind of personal/professional crossing as Peterson introduces herself to new students, i.e., by telling them that her first husband died of AIDS. By introducing herself in this way, and facing the 'frozen' faces of her students (who are unsure of how to respond to her disclosure), she intentionally steps into a stigmatized identity, and in the process, offers us a very different template of what it means to be an educator and a professional.

The blurring of these roles calls into question the (seemingly) distinct boundaries between the personal and the professional – suggesting that these lines may be more permeable than dominant discourses sanction. Narratives such as 'Are you a doctor?' suggest that the line between personal experience and professional role is not fixed, implying that we all can potentially shift (even temporarily) into the ambiguous space *between* personal experience, knowledge and professional expertise.

[46] See for example the stories 'From the Other Side of the Fence' and 'Me and Chucky' in Nisker, J (Ed.) *From the Other Side of the Fence: stories from health care professionals.*

Acts of translation: beyond 'chart talk'

I sometimes forget to speak in layperson's terms. I don't mean to sound authoritarian, but it is the language I learned during my training, my mother tongue, so to speak. I will admit that I sometimes need a translator for some of the jargon that is bantered back and forth.

From *Open Letter to My Patients* by Lori Robson in Nisker, 2008: 97.

Poet Jane Hirshfield (1997) suggests that translation plays an essential role in the "innumerable conversations between familiar and strange, native and import, past and future, by which history and culture are made"(55). The idea of translation resonates strongly here, as language is a highly contested area of healthcare practice and a critical site for the negotiation of meaning. Physician/writer Rafael Campo is concerned about the 'extremely scripted' conversations between practitioners and patients which cannot do justice to the complex stories of individual patients (in Birnbaum, 2004) and asks us to consider the impact of biomedical paradigms on our understandings of illness, identity and suffering. Referencing the larger complex power dynamics that occur in hospital settings, Campo suggests that the biomedical model reduces the patients' individualized highly complex stories into the 'coded language' of a highly scripted clinical note.

Katz and Shotter (1996) similarly point out that the note in the medical chart following a clinical interaction constitutes an "exemplar of how the patient's experience is translated into medical language and reduced into symbolic shorthand" (922). As the focus for medical practitioners is primarily biomedical, and thus the story often 'ends with diagnosis', for the patient the experience may be a more complex and indeterminate experience. Moving away from the abstract diagnostic language of the 'chart' allows us to focus on the particular and the practical – "a form of talk in which we are 'led' to see possible connections and relations between things that we had not noticed before" (926).

In analyzing the role of written documents in organizational life and healthcare practice, Hak explores how psychiatrists translate 'patient talk' and observed behaviour into formalized written records called 'charts'. In coding the everyday language of patients the practitioner selectively and narrowly represents the patient's experiences. In his analysis of psychiatric records on an inpatient hospital unit he states, "patients would talk to themselves, watch television, lend each other cigarettes, shout, laugh, go to work in the hospital workshops and so forth. Yet of such a myriad array of activity only a few are ever highlighted" (Prior, 2004: 380).

In looking at the records of the various healthcare practitioners dealing with patients (psychiatrists, nurses and social workers), he suggests that the records served in part to mark out the professional role and expertise of the practitioner. "Thus social work talk belonged in social work records, psychiatric talk belonged in medical records, and nurse talk belonged in nursing records" (Prior, 380). In commenting on the centrality of the 'written word' in healthcare practice, Prior states, "it is only when assessments are written down and can be pointed to, that they are used to form a foundation on which routine social actions are built... 'clinical writing' not only describes the treatment of patients, it also constitutes the treatment" (382).

In recounting how trainees are expected to abstract the details of someone's life into the general categories of clinical diagnosis, psychiatrist Robert Coles comments on what gets lost through the process of translating patient stories.

> I had taken her 'personal history', her 'family history', her 'social history', her 'clinical history' – all those phrases that were established in hospital residents' minds and formed distinct elements in the bureaucracy's code of procedures. Each patient's chart, that is, had those phrases printed on separate pieces of paper, and it was our task, as house officers, to take those different kinds of histories and write them up conscientiously... no wonder so many psychiatric reports sound banal: in each one the details of an individual life are buried under the professional jargon. We residents were learning to summon up such abstractions within minutes of seeing patient; we directed our questions so neatly that the answers triggered the confirmatory conceptualization in our heads. (Coles, 1989: 10-17)

Acknowledging that at times we use theory and jargon as "badges of membership" (Coles, 1989: 20), professionalized discourses typically focus on clinical categories rather than patient experiences. Aware of how the details of an individual life can become 'buried under medical jargon', Coles assumes a more narrative style of talking by asking a patient, "why don't you just tell me a story or two?" (Coles, 1989: 11). Trautmann Banks has a similar perspective commenting on the 'interpersonal intimacy' of nursing care is nowhere to be found in the standard medical chart where a hastily written phrase like 'patient in tears' or 'attempted to reassure him' function as an insufficient but expedient shorthand (Davis and Schaefer, 1995).

In discussing "narratives about doctoring", Montgomery (1991) describes stories about practice as "reports from the trenches" that tell us about something not included in the official case history. For Montgomery these narratives remain distinct from clinical notes or histories (although some of their "facts" may also be recorded in the medical chart), as essays, fiction and poetry "characteristically define themselves against the case history" (163). Acknowledging that 'unscientific' details like the relationship between patient and provider, or the practitioner's reactions to the patient, are not part of the official record, Montgomery suggests that our "thoroughgoing neglect" of such information has led to the pathologizing or minimizing of patient concerns.

Tom Strong (2012) explores the impact of 'symptom talk' in mental health practice and how clients' concerns get "named" through classification schemes like the DSM. Particularly concerned about the "medicalization" of human concerns (like the inclusion of grief as a psychiatric diagnosis), he also calls our attention to the reduction of conversational opportunities and alternative ways of conceptualizing life problems. While he points out that various 'discourses of helping' may expand linguistic and treatment options, such

systems also lead to "linguistic poverty which occurs when language uses and fails us in our ongoing negotiations with new people and new circumstances" and can marginalize approaches that resist translation into the language of the official chart (15).

Interested in approaches which elicit more "resourceful discourses of possibility" Strong (2012) states, "[w]hile clients typically present their concerns in one descriptive discourse, therapists have responded in others that, for the therapist, present more possibilities associated with their expertise... Therapists can also deconstruct diagnoses... [and] explore what any diagnosis leaves out of clients' understandings and yearnings... "(18). An alternative narrative could be constructed as part of a "counter-revolution" to the dominant paradigm which has favoured abstract forms of knowledge and classification systems (Engel, 2008: 42) by emphasizing everyday language.

These commentators draw our attention to the powerful effects of the "flattened prose of biomedical discourse" (Mattingly, 1998: 14), as well as the different discourses operating in healthcare settings. Mattingly (1998) describes the two separate, but intersecting, discourses that operate in healthcare practice as *chart talk (*which conforms to normative conceptions of clinical rationality) and *narrative or storytelling (*which permeates clinical interactions but is closer to everyday speech and has no formal status in the official record). I agree with Mattingly that while both discourses are useful, they lead to very different places and that clinical notes and institutional records can 'only tenuously refer to the rich complexity and subtlety of the therapeutic encounter' (Swartz, 2006). I like the idea suggested by Stein (2007) of looking at narrative writing as a kind of "auxiliary clinical text" (17) – useful for making explicit what normally remains unsaid in institutional discourses – thus inviting other kinds of "relational possibilities" (Gergen, 2008).

In contrast to professionalized "chart talk" (Mattingly, 1998), narrative can help us position ourselves differently in our relationships with clients and patients. In her study of occupational therapists in hospital settings Mattingly (1998) highlights the 'undocumented exchanges' and 'underground practices' between therapists and patients dealing with illness and disability. Writing that small generosities and acts of kindness towards patients are 'not the stuff of the medical chart', and thus not officially recognized, she states, "there is almost no language within biomedical discourse for recognizing and examining exchanges which... run counter to the dominant metaphor of body as machine that holds such persuasive force in Western medicine" (22).

Sally Denshire (2001) also questions the language of clinical suggesting that while we need to understand medical terminology, it is equally important to deconstruct the language that we use as practitioners which "unwittingly does not do our practice justice" (155). Interested in unpacking clinical practice and giving it "language and meaning", Denshire suggests that the language of everyday practice constitutes a kind of 'in-between space' as

'this work was often done in corridors and can be thought of as an 'underground practice' (157).

Social work professor Adrienne Chambon (2005) also writes about the importance of 'filling in the blanks' left out of official clinical documentation or case records through narrative and other 'alternative ways of telling' as she states, "the blanks tell the other side of the story. What is missing is as much present as what is told... Narratives that take as their material the habitual stuff of life, that start with what is around us... [as a] tension appears between what we think we know and what we don't quite know (5). Social worker Rita Wilder Craig (2007: 433-434) reflects on the importance of filling in the missing pieces through writing personal narratives of her work:

> [After a] particularly gruelling day where I had seen patients who were dying, families with elderly relatives needing placement, one man needing cardiac rehabilitation, and finally I facilitated a meeting in the Intensive Care Unit... I returned to my office exhausted – sat staring at my computer and thoughts about doing notes and entering my statistics. But instead of writing notes I started writing about my day.

Craig suggests that it is the ability to write/tell the story of her day that provides an opportunity to reflect on feeling 'disconnected, afloat in a sea of the day's distress' and provided a valuable antidote to the 'absurdities encountered in everyday practice' (434).

Social work professor Amy Rossiter (2007) examines how professional discourses potentially objectifies clients. In examining common clinical assessment practices, she suggests that we inadvertently "mark" our clients through "the gaze from nowhere", and construct the official version of their lives through documentation. The lack of reciprocity is particularly troubling to Rossiter as practitioners remain "unmarked" as clients are described from the invisible yet powerful location of professionals. Notions of professionalism, as enacted through documentation practices, thus allow practitioners to escape the relational dimensions of practice and perpetuate unspoken assumptions about the objectivity and professional distance of practitioners (Rossiter, 2005).

Medical educators Trisha Greenhalgh and Brian Hurwitz write about how students lose their facility for eliciting and appreciating patient's narratives during the process of learning to construct a standardized clinical history where patients' symptoms are understood through a diagnostic lens. In this way, students move away from 'everyday ways of talking' – losing the ability to recognize the lived experience of patients as they internalize the thin discourse of clinical practice. Commenting on how the curriculum of modern medicine lacks a 'metric' for adequately describing the lived experience of patients, Greenlaugh & Hurwitz (1999: 3) suggest that

> the relentless substitution during the course of medical training of skills deemed 'scientific' – those that are eminently measurable but unavoidably reductionist – for those that are fundamentally linguistic, empathic, and interpretive should be seen as anything but a successful feature of the modern curriculum.

In her exploration of clinical case notes (referred to as 'the textual records of therapy sessions'), psychologist Sally Swartz (2006: 428) suggests that poetry allows for the construction of richer accounts of practice than conventional clinical documentation. Arguing that case notes are often "little more than dry lists of dates, payments and skeletal 'factual' accounts that only tenuously refer to the rich complexity and subtlety of the encounter", she suggests that

> the wisdom of the poet lies in their knowledge that truth is not 'fact', that our clumsy attempts to make language represent reality in some transparent way lets loose exactly what we hoped to capture in our web. The music, the shape of a word, its historical resonance, tells far more than any accounting column can.

In the following poem family physician Robert Blake[47] calls attention to how clinical language practices serve to disconnect practitioners from patient experiences, and cast an objectifying lens on patient stories.

Poem: The Poor Historian

I was sitting in the conference room
hoping to be helpful.
In came a resident
to present a patient.
A forty year old female was
Complaining
of headaches.
She was a poor historian.
She Complained
of feeling tired and having no energy.
She Denied
trouble with her vision.
She Denied

---

[47] Accessed 5 April 2013 from www.jfponline.com/Pages.asp?AID=2168

smoking, but
Admitted
to drinking a few beers each day.
She Complained
that her husband did not pay attention to her.
She Admitted
having conflict with her daughter.
The resident seemed pleased with his history;
He had addressed psychosocial issues,
with a poor historian, no less.
I asked him.
When you go to a doctor for help,
do you complain?
Do you deny?
Do you admit?
He looked at me,
a little perplexed,
then a little perturbed.
We went to see the poor historian.

This poem strikes me as an attempt to say something about the way we speak *about* patients, as well as calling attention to missed opportunities for teaching about the often "callous jargon"[48] of healthcare practice. This poem makes explicit the potentially objectifying impact of clinical language, as well as the 'bilingual' aspect of healthcare practitioners' interactions with patients. In acknowledging the acts of translation that are embedded in clinical interactions, Blake makes visible the ways that the clinical gaze translates the everyday language of patients into negative acts of 'complaint', 'denial' or 'admittance' (which begs the question, what are they *admitting* to?). In exploring the presence of negative emotions, such as blame, shame and fear, in clinical interactions, Charon (2006: 31) points out that

> patients are routinely blamed by doctors for the oddest things. 'Patient is a poor historian', doctors typically say when they cannot follow a complex story of an illness. 'Patient noncompliant' says the doctor whose advice to take certain medicines is declined. Such descriptions as 'morbidly obese' and 'sexually promiscuous' transform a physical or behavioral description into not only a

[48] From presentation by philosophy professor Craig Irvine at the Narrative Medicine Workshop, Columbia University, June 2011.

moral judgment of the patient but also an accusation that the patient caused whatever ails her.

Chan (2008) points out that healthcare practitioners unreflectively use "ritualized practices"' to make patients wait – and then expect patients to be cooperative and passive. Patients that step outside of this script are labelled difficult or demanding. This is reminiscent of other pathologizing labels, like the 'unreliable patient', that practitioners circulate unquestioned about patients.

Based on her own experiences of living with a chronic illness, writer and patient advocate Julie Devaney states that the idea of the 'unreliable patient' is based on the notion that patients cannot reliably tell you what their medical history is or what they need. This leads to healthcare providers not listening to patients and ultimately, to poor care. "I think the starting point that patients are not 'reliable' narrators of our own experiences and our own bodies is a problem for everybody (including doctors) because they need to be able to trust that we can have a conversation".[49]

Blake's poem also makes visible the process of "abstraction and increasing distance from the lived experience" of the patient – an approach that ignores how meaning is generated through interaction. While conventional training teaches students to "take histories", what we are really doing is "creating histories" (Engel et al, 2008: 25). This poem makes clear that constructing the "story" of an illness in a clinical setting is a collaboration involving the patient and providers. As Engel et al (2008) write, "when health care practitioners interact with patients, they jointly are writing new chapters or revising existing chapters in their stories – both the patients' and their own stories" (53).

Cultural anthropologist and medical educator Howard Stein (2011: 31) critically examines language practices that occur in clinical interactions through his writings. In the following poem, he calls attention to the "foreign tongues", or different discourses, operating in clinical settings, calling into question who has the power to impose meaning on patients' experiences.

Poem: 'Methodology' or Hurting a Ten or a Zillion

"On a scale from one to ten,
With ten the worst,
How much did your debridement hurt?"
Said nurse to boy.

---

[49] From an interview with Julie Devaney on CBC Radio, Sept 26, 2012.

"A zillion"– said his mouth,
A cowboy's grudge against too much.
She circled "ten" and moved along.
His parents looked on.
They thought of burns and death
Or maybe that it never happened
How much more he would endure
Before the bronc gave one final throw.
They stood on Ellis Island, too,
Where their parents had been processed
In long queues and with inept questionnaires,
The boy's nurse, now an immigration officer.
Each addressed the other in a foreign tongue;
But only one recorded the event,
Decided what the family's proper name should be,
And whether it hurt a zillion or just a ten.

This is an evocative and layered account of a seemingly ordinary clinical encounter. The poem opens with a nurse asking the boy/patient to 'rate' his pain from one to ten during a debridement procedure.[50] While the boy rates his pain 'a zillion', the nurse records the response as a simple 'ten and moves along'. I would suggest that in this act of 'translation' (changing the boy's words to fit a standardized pain measurement), the nurse has effectively erased the boy's own expression of his experience. This is consistent with the trend in modern practice to "dismiss the patient's [so called] subjective account of illness as unreliable and irrelevant" (Engel et al, 2008: 23), in that moment it is the nurse that has the power to enforce meaning on the boy's experience through her act of documentation.

This strongly echoes Frank's (2004) argument that what does not fit the (dominant biomedical) narrative does not register as experience and is thus rendered invisible by healthcare providers. In his reflection on how pain is responded to in clinical interactions, he points out that using standardized questions or measures for patients to rate their pain can be a useful strategy – "like any tool, it is perfectly useful in the right situation" (212). But he is more concerned with the indiscriminate use of such tools where practitioners have lost

[50] Debridement is the process of removing dead tissue from ulcers, burns or wounds to speed recovery. Asking patients to rate pain on a 'pain scale' is a common way of assessing and recording pain in clinical settings. Usually based on a scale from zero to ten, patients are asked to assign a measurable number to their pain level. For example, zero represents no pain at all while ten represents the worst imaginable.

the ability to speak from their own perceptions and sensibilities. Following such a 'script' leads to a lack of empathy and moral failure as providers are unable to pay attention, and respond, to the particularities of the patient's experience and suffering. For Frank this is a failure of narrative imagination as both provider and patient are 'alienated' and lack the ability to understand each other.

This brings us to the family's immigration experience as suggested by the phrase 'processed in long queues with inept questionnaires'. Juxtaposing the nurse with an immigration official, Stein suggests that they are both in the position to change the family's very identity through the act of naming. The translation processes involved are implied by Stein's use of the phrase 'each addressed the other in a foreign tongue'; as this could apply to both the experience of the family with the immigration officer as well as the experience of the boy and his parents with the nurse.

While each seems to be speaking their own language, the poem suggests to me that it is only the nurse and the immigration officer, not the patient or family, that hold the power to name themselves through language. As Stein states, 'but only one recorded the event / decided what the family's proper name should be / and whether it hurt a zillion or just a ten'.

In drawing our attention to how 'patient complaints are turned into generalizable concepts' (Engel, 2008: 25), we are left to ask what ultimately gets left out of such descriptions? The use of standardized assessment tools, structured "yes-no" questions, numeric scales, and an overall increased reliance on technology, has led to the depersonalization of clinical care and decreased the patients' opportunities for storytelling (Engel: 75).

I would suggest that Stein's poem explores how patients' words get translated into a clinical discourse that does not do justice to their experience – and in that moment we lose the opportunity to recognize the other and to engage in genuine dialogue. In that process of translation we turn opportunities for generosity and connection into silence and failures of connection (Frank, 2004: 26).

Exploring what gets left out of official records in a different way is the subject of a poem by Ebner (Schaefer, 2006) which chronicles a day in the life of a visiting home care nurse.

Poem: Daily Activity Log

6th visit
Grandiosity gone in the next patient,

there, in a shamble
Of house where the roof leaks and the eaves
are filled with leaves.
Her face, bruised – What happened to you?
I tried to call the police,
He kept, kept slamming the phone
Down. I can't move my goddamned arm.
Her spouse, now in his drunken sleep upstairs, had dragged
Her into the kitchen.
You can call the police now, if you want to,
And when they take him away.
The way he looks at me I know he wants to kill me....
Employee name. Title. Company branch.
Odometer start. Odometer end. Time in
Time out. Total number of miles traveled.
Total amount of time spent in the home.

In this poem we see the juxtaposition of how the nurse documents what happens in the course of her day with what she records in the official record. The official record represents the visit in terms that can be easily quantified – miles travelled, minutes spent in home etc. The last statement the client makes to the visiting nurse is an ominous "the way he looked at me I know he wants to kill me." Yet the nurse only chronicles information in her daily log such as distance travelled and time spent. While the official record captures what can be easily categorized, the poem makes clear that there are important 'details' that get 'left out' of this official recording.

While the visiting nurse is confronted with a tale of domestic violence including a bruised face, a drunk spouse, and a broken arm, none of these important 'details' are visible in her documentation. In fact, there is literally no space for such information. Ultimately the poem encourages us to move away from the idea of healthcare providers as "simple technicians completing care and checklists framed within set times and places laid down in the journey script" (Kent, 2008: 55) and invites us to ask ourselves "what really counts?" In pondering the question of "what counts?", the poem 'Cleft'[51], by family physician Jon Neher, entices us to step outside of usual professional discourses to a more relationally responsive way of interacting with patients.

[51] From www.pulsemagazine.org/Archive_Index.cfm?content_id=94 Accessed 5 April 2013.

Poem: Cleft

As Caroline was born
the doctor saw
the split
from lip to nose–
purple rimmed,
going down deep–
Deep enough
to hurt
generations.

And the imperfect doctor,
tired of wounds
tired of divisions,
saw the small
wholeness
Chose that moment
Chose tenderness
saying simply,
She is beautiful.

And the imperfect mother,
tired of pain,
held her child,
touched the tiny,
ragged face
Chose that moment
Chose acceptance
crying softly,
She is beautiful.

Neher explores his experience, as a new physician, of trying to find the 'right words' for a difficult situation that called for a certain kind of relational sensitivity. Neher seems to be choosing his words in the poem carefully – as he does in the clinical interaction he is describing. He seems to be acutely aware that how he responds in this critical moment will shape the meaning of the birth for this family long afterward.

In his reflection on the writing of the poem, Neher acknowledges that due to the unexpected nature of what happened, and his relative inexperience as a physician, he had no 'professional scripting' to fall back on. It is perhaps his lack of facility with professional language that allows him to rely more on the language of everyday life – and encourages him to choose the less clinical – and ultimately more empathic – response.

We can also view this poem as an attempt to sidestep the (dominant) bio-medical discourses surrounding disability – the disempowering interpretations of disability and impairment that circulate in clinical settings (Fisher and Goodley, 2007). In this way his response can be understood as contributing to the construction of a sort of "counter narrative" offering an alternative and more 'joyful' account of the birth – one that helps parents 'enjoy their children as they are'. In some ways this poem celebrates many "imperfections" – the imperfections of the doctor, the baby, and perhaps the mother.[52]

While not ignoring the immediate issue (the cleft palate), the doctor is still able to sustain the connection with the family and enter into what Frank (2004) might call a *relation of care*. In emphasizing the importance, as well as the fragility, of relational attunement in critical moments, the poem evokes the role of language in the connection between practitioner and patient. In repeating the line "she is beautiful" by both the doctor and the mother, we see not so much the merging of two voices as the dance of connection through language. Neher reflects on the personal meaning of this poem stating,

> this poem was written to capture the layering of emotions that occurred the day I unexpectedly delivered an infant with a cleft palate. I was new to my career, and this was a novel challenge for me. Since I had no professional scripting to fall back on and because I wanted to encourage bonding, I found myself repeatedly saying how beautiful the baby was, even as I discussed the cleft with the parents. The effect on the family was precisely what I was hoping for.

One of the most striking accounts of the divide between official records and the experience of the patient can be found in the piece "Babel: the Voices of a Medical Trauma"[53] written by Tricia Pil. As a practising physician at that time, Pil describes the traumatic

---

[52] This can be sharply contrasted to the account of a birth discussed in Engel et al (2008) on a workshop on personal narratives of illness. He writes about a mother (now in her sixties) who stated: "during childbirth and while she was still groggy from the sedation, her obstetrician told her, 'we think your baby has Down's syndrome. But you can have another child'... the storyteller related how hurt and angry she felt at the way he delivered the tragic news" (187). Despite loving her son deeply, the remark from the physician was the beginning of a 'troubling story' about her son and his disability.

[53] For the full account of this story and a video of the story being read in three voices see www.pulsemagazine.org/Archive_Index.cfm?content_id=119. Accessed 28 March 2013.

delivery of her son, as well as her subsequent feelings of betrayal at her healthcare providers as she struggles with medical complications and the psychological impact of what occurred during her hospitalization.

It is the isolation, avoidance and silence (beginning with the labour and delivery room nurses immediately after the delivery and continuing with her own physicians and the hospital representatives) that inspires Pil to write her story as a narrative in three distinct points of view or voices: first, the story as recollected by herself as a patient; second, the events as recorded by the doctors and nurses in the chart; and third, the version of events as later described by the hospital in response to her concerns.

Story: Babel: the Voices of a Medical Trauma (excerpt)

Patient:

My water breaks the following night, and I call Doctor B. After saying "Hold your horses," he grudgingly tells me to return to the hospital. By the time we arrive, my contractions are coming every minute. No one is behind the emergency room desk. My husband finally finds an off-duty orderly willing to get a wheelchair to take me to the birthing center. There, the secretary refuses to call a nurse until I sign papers explaining the hospital's privacy policies.

Chart:

Registration 10:45 pm. Triage admission 10:45 pm.

Hospital:

After 10:30 pm a call bell is present on the counter in case the triage nurse is not at the window. The "off duty orderly" who wheeled you upstairs to the birthing center may not have known the proper sequence to follow. Documented registration time is 10:45 pm and the time placed in the triage room is 10:45 pm which indicates swift placement into a triage room. There are some forms that must be signed for each admission.

This brief excerpt from the narrative suggests the sometimes intersecting, but more often discordant, stories created by the various participants in the unfolding medical drama, and the power of institutional discourses to shape the "official" story. While her experience as a patient gets lost in the institutional account, it is Pil's intention to present her story so

that her own experience can be written and shared so we can "rise above the babble of Babel" and move towards more caring and accountable healthcare practices.

In wanting to further explore the space between the 'language of the chart' and the more 'everyday language' that emerges in practice, I wrote a poetic account of a counselling session that left me with lingering doubts and questions. Inspired by the poem "Just This" by Ronna Bloom, I view my poem as part of ongoing conversations within my own practice as a social worker.[54] If we think of poetry from a dialogical perspective as 'inviting' a response from others, then my poem can be read as a response to Bloom's poem as well as an attempt to continue the conversation.

Bloom's poem has become part of my internal dialogue in which I struggle with tensions and dilemmas in my own practice. As Gergen (2009) notes, the metaphor of internal dialogue (or inner conversations) is useful as it acknowledges the 'voices' of other relationships that we carry with us – also referred to as "invisible guests" – and reminds us that meaning remains under 'continuous development' (145). My poem provides an opportunity to explore the residue of an ordinary and fleeting moment in practice – moments that often disappear unnoticed or are translated into the unsatisfactory language of the official chart. In this way, the poem speaks to the disorienting disjuncture between what is written in the chart and the story that unfolds in the conversations of day-to-day practice.

An appreciation that multiple discourses circulate in clinical practice – in particular, the language of everyday experience, storytelling and chart talk, has inspired my response to Bloom's poem "Just This" (Bloom, 2000) in the form of a poem entitled 'A Space for Stories'. In attempting to create a dialogue between the two texts, I have incorporated lines from Bloom's poem that "strike a chord with me" (shown in italicized text) at both the beginning and ending of my poem.

Poem: Just This

A friend says she thinks we're not wired
for this much intimacy, for knowing so much
about so many lives. Last week I joined her
in the group she runs, all the women survivors

---

[54] Ronna Bloom is 'Poet in Community' at the University of Toronto where she uses writing to create a "third space" defined as "not as formal as a classroom, or as casual as a coffee shop. It's a facilitated learning experience without evaluation." She is currently Artist in the Workplace at Mt. Sinai Hospital in Toronto. See www.poet.utoronto.ca.

of violence: one-off randomness and deliberate
consistent relentless assault. She is gentle in the room
almost whispers and this is what she offers:
a space for them to speak or not, to cry or not,
to leave or not, to listen. It sounds cliché but the space
for pain is underrated.
A voice in me was crying: this is what I always wanted
my family to be, just this: a room and five people in it
and enough quietness to hold all the shrieking
or all the fear or all the desire or all the love,
a room with people in it.

Poem: A Space for Stories

A friend says she thinks we're not wired
for this much intimacy, for knowing so much
about so many lives.

Like the woman I saw the other day
No hint of her real life dramas
in the medical chart I glance at quickly
before I call her name. Seated in the
worn chair in the make-shift counselling office,
she tells me of old hurts and painful betrayals
her stories landing in the space between us.

I want to say something useful, to do justice
to what she has offered me, but I can't find
any words that won't sound hollow
or something she doesn't already know.

Yet there's room here, I tell myself,
for letting the stories fall
and just letting them be.

It sounds cliché but the space for pain is underrated.

I view my poem as an exploration of a practice situation that left a 'lingering discomfort' as well as an opportunity to "see differently" (Kinsella, 2006: 41). Bloom's poem provides an opening for me to reflect on both the limits and possibilities of therapeutic conversations, as well as to think differently about issues of silence in therapeutic encounters. This reminds me of Shelley Green's caution to practitioners and researchers about being open to the stories clients bring: "how can I listen to the story that needs to take priority? This is our dilemma as therapists and researchers: how to let the story be, how to keep from needing to intervene" (Flemons & Green, 2002: 188).

My poem can also be read as an imagined conversation between the client and me – a conversation we were not able to have. If my poem expresses something that I would have liked to say to her, but could not find the words, it can be seen as an attempt to 'fill in the blanks' and correct a missed opportunity for dialogue. Perhaps my poem is an attempt to create something meaningful out of a momentary 'breakdown' of communication – or at the very least act as a witness to the story offered me. It reminds me of the paradox, described by anthropologist and medical educator Howard Stein, that we often require words to articulate the limit of words.[55]

My poem acknowledges the residue of a fleeting moment in practice – moments that often disappear unnoticed or get translated into the unsatisfactory language of official documentation. In this way, the poem speaks to the tension that I carry as a result of the "professional rhetoric we are socialized into, and to which we are accountable" (Kinsella, 2006: 43), and the gap between what is written in the chart and what is spoken in the counselling session.

With the intention of enlarging the conversation, I sent Ronna Bloom the first draft of an article I had written about constructionist inquiry, relational poetry exploring my response to her poem (see Gold 'A Space for Stories'). I invited her to respond to the ideas of relational poetry and, in particular, her feelings about my use of her poem for the purpose of shared inquiry. I was especially interested in her feelings about my 'borrowing' her lines and incorporating them into a new poem. While her poem clearly "struck a chord" with me, would she, as author of those words, see it as a compliment or as an appropriation?

Since then, we have had several conversations about writing, the relationship of writing to practice, and the notion of dialogue through poetry. Currently artist in residence at a teaching hospital, Bloom also reflects on these issues. Our conversations have enriched my reflective process in unexpected ways. I wanted to bring her voice, as writer, into the

---

[55] Howard Stein's poem "Dimunition" addresses the notion that "less is often enough, even better" as his poem "is trying to teach me something–about living, sickness, death and the limits of words. It also reflects the delicious paradox that we often require words–even few words–to articulate the limits of words!" Accessed 5 April 2013 from www.pulsemagazine.org.

conversation more explicitly, so I include here some of her thoughts on our 'relational poem':

> What I did feel was that your poem felt completely in relation to mine. Yes, 'inspired by' works too. But if I think of a poem as a whole organic being (something I've never said before) I felt 'the poem in me' was 'heard' (and responded to) by yours. Does that make sense?

In this section I have explored language as an in-between place in healthcare as different discourses constitute a type of (cultural) translation. This discussion has highlighted both the importance of language in clinical interactions and the potential gap between institutional discourse ('chart talk') and the more everyday language of both practitioners and patients. In the next section, I turn to an exploration of a different kind of liminal experience – the space between knowing and not-knowing and how practitioners navigate uncertainty and ambiguity in day to day practice.

Between knowing and not-knowing

A collaborative [practitioner] takes a sceptical and tentative approach to knowledge, including its substance, its use, its certainty, its risks, and its implications… Maintaining a not-knowing position and living with the uncertainty that accompanies it is vital for the freedom of expression and for the natural unplanned paths of dialogue.

Harlene Anderson, 2007b: 48-50

We just do not see how very specialized the use of 'I know' is for 'I know' seems to describe a state of affairs which guarantees what is known, guarantees it as a fact. One always forgets the expression 'I thought I knew.'

Wittgenstein in Westphal, 1995: 83

> ... it is when the doctors and nurses / think they know everything/ that we are in trouble.
>
> Carmen Maggisano, 2008: 50

Questions like 'How do I know what I know? What images have influenced or shaped my identity formation, both personally and professionally?' (Maggisano, 2008: 13) are important as they raise the dilemma of (un)certainty and knowing in professional practice. In speaking about dialogue in healthcare practice, Frank (2004) writes, "At a moment when two human beings share feelings of uncertainty, lack of resources and loneliness, dialogue is most possible between them. At such moments... it is possible for each to drop his tone and speak with a human voice" (20).

If moments of uncertainty are indeed opportunities for connection, Stein argues for the value of not-knowing, or "holding knowing in suspense", to cultivate creativity and imagination (2007: xv). As he states, "For me, the essence of reflective practice – clinical, organizational and otherwise – is the cultivation of living and working at the boundary, the edge, between knowing and not knowing, of knowing while at the same time knowing that I do not or might not know... (Stein, 2007: 118).

Poems often move in two directions at once, "between knowing and having no idea" (Rosen, 2009: 97), and nurse/writer Shirley Stephenson acknowledges that 'there is no map and no way to pack for certain journeys' (from the poem 'I'm Staying' in Sergi and Gorman, 2009). If professional practice is characterized by a cloak of competence, we need to concern ourselves with how practitioners navigate the unfamiliar territory of uncertainty and ambiguity. Charon (2006) points out in her discussion of the imperfect and complex world of day-to-day clinical medicine that doctors typically feel unable to measure up to 'inflated expectations and demands' of patients (21), and are ill-equipped to deal with the fears, loss and disappointment that patients may experience.

In contrast to expert-driven stances, practitioner narratives challenge 'modern regimes of care' (Mattingly, 2010) by constructing a different landscape of practice characterized by curiosity, 'not knowing', and a recognition of the limits of an expert driven stance. If certainty is a hallmark of conventional professional discourses, then the following narratives call into question the often unexamined assumptions about what it means to be a healthcare practitioner, and how practitioners move between *knowing and 'not-knowing'*.

While understandings are shifting to acknowledge that in the world of professional practice 'nothing ever is, all is becoming' (Mullavey-O'Byrne & West. 2001), our notions of what it means to be a healthcare professional still imply a high degree of certainty. Drawing on the definition of certainty as an 'undoubted fact' or 'beyond the possibility of doubt', it

seems that the complex realities of healthcare practice inevitably means 'confronting the certainty-uncertainty problematic' as 'the quest for certainty, or at least the deep-seated desire for such a state, is a silent partner in almost every encounter between a health care practitioner and a client" (Mullavey-O'Byrne and West, 2001: 55).

In *My Leaky Body* Julie Devaney writes about the resistance of healthcare providers to collaborate with their patients arguing that it is assumptions of "professional expertise" that discourage it. Discussing her ten year struggle to get properly diagnosed and treated with a debilitating chronic illness, she chronicles her many visits to emergency rooms, hospitals and doctors' offices where she suffered a series of self-described "humiliations" and frustrated attempts to get appropriate care.

> [I]n modern medicine doctors are really trained to be the expert and to "manage" patients... there were times I was really clear about what I needed or how to move forward where I would end up having an ego war with the doctor who just wanted to get things down... but they failed to listen to me and there were often severe health consequences... We should be collaborating, we should be on the same side, but it often ended up being a conflict.[56]

The current drive towards protocols, checklists, clinical practice guidelines, and other forms of 'evidence based practice' strategies, evinces the ongoing 'quest for certainty' in healthcare practice. Nevertheless, there is increasing acknowledgement that many clinical decisions are based on the personal experience and judgment of the practitioner and Charles (2001) points out that uncertainty plays an important role in clinical decision making. There is increasing emphasis on the acceptance of uncertainty, as well as a more collaborative and patient-centered focus. In challenging the privileged position of positivist research over other types of knowledge, a post-modern healthcare practice would 'consciously adopt a therapeutic position of uncertainty' (Charles, 2001).

Part of an ongoing conversation to "unravel the seeming security of your grip on what you think you know," (Rosen, 2009: 67) McNamee suggest that a 'reflexive stance towards uncertainty' is an important component of inquiry, for it challenges assumptions about the role of expertise in professional practice ideologies.

> The idea of uncertainty confronts the notion of Western rationality and logic that presumes a "good" person, a "smart" person is a "certain" person – one with certainty about the world. We mark the expert and the professional by the clarity of their certainty. Thus, it is a sign of incompetence for a professional or a scholar in our culture to say, "I'm not sure, what do you think?" This is

---

[56] From an interview with Julie Devaney on CBC Radio 26 September 2012. Accessed 30 March 2013 from www.cbc.ca/thecurrent/episode/2012/09/26/my-leaky-body-julie-devaney.

> unfortunate because being certain (right) inhibits any possibility of thinking together or of relationally crafting possibilities (2012: 154).

While pointing out that a 'not knowing' stance does not mean that a practitioner is a 'blank slate', McNamee (2008) acknowledges that uncertainty is an 'uncomfortable space' for professionals to occupy as our understanding of expertise emphasizes certainty and professional authority. She suggests we use a dialogical metaphor for practice which acknowledges that "we are steeped in uncertainty, incompleteness, and multiplicity. This may appear to be a very uncomfortable space to occupy. After all, we place high value on just the opposite: certainty, completeness, singularity... "(9). Assuming a more collaborative stance requires a critical examination of our expert positions (McNamee, 2007: 315) as such conversations assume unpredictability as "we never can know ahead of time exactly where the conversation might go next" (Guanaes and Rosera, 2006).

Reminiscent of the poet John Keat's notion of 'negative capability', where one is capable of living with uncertainties (cited in Rosen, 2009: 139), we can turn to collaborative therapy approaches for a further understanding of 'not knowing' as a practice stance. Not to be confused with the idea of 'knowing nothing', the concept of 'not knowing' in therapeutic conversations was introduced by Anderson and Goolishian to refer to a stance of genuine curiosity on the part of the therapist/practitioner, a focus on listening to the client's story and an interest in joining with the client in a collaborative exploration of her experiences (Rober, 2002).

A not-knowing stance can mean that a practitioner "is open to the possibility of myriad meanings, [and can] refrain from being "too quick" to know what the clients are talking about, and to approach the therapeutic conversation from the stance of genuine curiosity for the *local coherence* of the client's situation" (Guanaes and Rosera, 2006). Anderson writes that a 'not knowing' stance in therapy approaches involves curiosity on the part of the practitioner who invites clients into expert positions on their own lives (Anderson, 2001) and can in fact liberate practitioners from having to know everything.

Cheryl Mattingly writes about how patients and families navigate the terrain of critical illness and disability when they are confronted with the limits of biomedicine. Exploring how hopefulness and despair are constant companions to serious illness and disability – and exist in a kind of 'paradoxical border' – she writes that "the rise of new biotechnologies has provoked new reconsiderations of social hope and clinical care while also emerging as a kind of Frankensteinian monster" (cited in Mattingly, 2010: 5). Mattingly asserts that the "dark side of this utopian hope has been repeatedly exposed" (2010: 55) recalling Foucault's dystopic analyses of 'modern regimes of care' in which he describes the potentially objectifying effects of the professional gaze as patients are 'guarded, disciplined, examined and punished'.

Not denying that certainty is a desirable goal in matters of medical diagnosis and treatment, family physician Caroline Wellbery (2010) explores the role of uncertainty and ambiguity in clinical practice as it acts as a useful 'counterforce to the unexamined quest for definitive answers'. She suggests that poetry and visual art have a unique role in health professional education, as they enhance our understanding of the interpretive dimension of practice through self reflection. As she states, art may help us 'ride the uncertainty' by embracing ambiguity and uncertainty.

Aware that many students in healthcare settings think poetry is a "waste of time", medical educator Danielle Ofri continues to try and address the dilemmas around 'knowing' through narrative; to use poetry to acknowledge that "fear of not knowing is a constant companion" in clinical practice. She explores this uncomfortable territory in the following piece "The Poetry Ward: A doctor dispenses poems to patients and medical students."

Story: The Poetry Ward

At the end of each month, I get up the gumption to present a four-page poem. This requires bribery on a grander scale, so I temporarily relax my insistence on healthy food and present a double-fudge chocolate-mousse cake, studded with die-sized cubes of dark chocolate. I plunge into John Stone's "Gaudeamus Igitur." Written for a medical school commencement by a cardiologist-poet, the poem is appropriate for the end of an intense month-long rotation before our group is scattered to the far-flung reaches of the hospital.

Stone borrowed the form of his poem from Jubilate Agno, by the 18th-century poet Christopher Smart, in which each line begins with the word "For" or "Let." What captures my students' attention, as they wolf down their cake, is the blend of clinical references (letting them know they are in the know) and pithy lines that perfectly capture their mixed emotions about being doctors.

> For this is the day you know too little
> against the day when you will know too much.
> For you will look smart and feel ignorant
> and the patient will not know which day it is for you
> and you will pretend to be smart out of ignorance
> For you must fear ignorance more than cyanosis.

Those lines bring knowing nods and uncomfortable squirms. They have all – we have all – been in this position. The fear of not knowing enough is constant in medicine...[57]

[57] Accessed 30 March 2013 at www.poetryfoundation.org/article/178455

Ofri's reflections on this teaching scenario, particularly her doubts and hesitation in using the poem with her students (even 'bribing' them with cake!), captures the ambivalence of health professional educators towards the use of narrative in their work (perhaps reflecting the larger ambivalence of the healthcare professions towards the arts in the scientific enterprise of healthcare).

The lines "For this is the day you know too little / against the day when you will know too much... For you will look smart and feel ignorant... and you will pretend to be smart out of ignorance" suggest that practitioners' have a complex relationship with the positions of 'knowing' and 'not knowing'. In particular, her suggestion that students (and practitioners) can expect to vacillate between 'knowing too little' and 'knowing too much', challenges the often unquestioned assumptions about professional expertise.

The fragility of emerging professional identity and expert driven knowledge claims is explored in a different way by medical student Alim Magji. Calling into question notions of expertise and knowing in professional practice and identity, Nagji writes in "Nervousness" about her medical training and the dissonance between the image others hold of her ("the epitome of a good person") and her sense of personal vulnerability and discomfort at being thrust into the role of 'expert'.

Story: Nervousness

> But somehow talking to people leaves a bitter taste in my mouth. I should love the sound of my own voice, but it rings hollow and metallic. When I catch my reflection in the mirror, I look away. Mirrors are unnatural, why should we see what we truly are? It has only been a year, so my superiors challenge me: if they survived so long, why then have I become lost so quickly?... After one month of sitting in a chair I will be expected to treat someone, I will be invited into their homes and lives, called upon in their weakest moments as the expert. I will stand in front of them, hiding behind a white coat and fancy Latin terms, when truly I will be naked... I am no longer a real person. I eat and sleep and regurgitate facts with startling efficiency. I weep when I should and laugh, sometimes inappropriately. It's really the only humanity I have left.[58]

In looking at her own reflection, she is uncomfortable and struck by the transformation she sees which forces her to 'look away'. As her professional knowledge and identity develops ("hiding behind a white coat and fancy Latin terms"), she notices that her sense of humanity, and ability to connect with others, grows smaller. While her emerging identity as

[58] Accessed 30 March 2013 from University of Alberta Health Sciences Journal www.uahsj.ualberta.ca/files/Issues/6-1/pdf/20.pdf.

a healthcare practitioner should imply confidence and a sense of competence ("I should love the sound of my own voice"), her voice rings hollow, signalling perhaps her sense of disorientation and loss.

Recalling her sense of isolation and powerlessness when caring for a seriously ill elderly man as a student many years before, Charon (2006) writes that while there was little to be done medically, she had not yet developed the relational skills or resources to effectively respond to him or his family. "I did not know that I was allowed, as a doctor, to donate my presence, my attention, my regard" (34). Driven by her own fear of incompetence, her relative inexperience and the memories of her own grandmother's death, Charon wasn't able to see that she could confront a sense of powerlessness by offering what was most needed: "honesty, support and courage" in being an empathic witness.

Nagji captures well the "space of detached concern" described by Halpern and others (cited in Engel et al, 2008: 226) where practitioners are taught to guard themselves against connecting with patients in anything more than superficial ways. While this may function as a protective mechanism against the seemingly overwhelming demands and needs of patients, it may lead ultimately to dissatisfaction and disengagement with one's work. Their warning that with her "humanity gone, replaced by the sterile world of technical medicine, the chances of burnout become greater" seems to echo Nadji's account of her present practice.

While Ofri identifies the 'fear of not knowing' as a constant companion in the practice of medicine, other writers explore the limits or boundaries of biomedical knowledge. Speaking directly to an uncomfortable, and often unarticulated, sense of powerlessness, family physician and educator Frances Wu articulates her sense of helplessness in the face of slowly declining health in the appropriately titled poem, 'The Limits of Medicine'.[59]

Poem: The Limits of Medicine

I can not change the color of the sky.
The texture of the rain,
the distance of a star
must needs be fixed

by ancient ritual

unaccepted by our modernity
I have been roundly trounced

---

[59] Accessed 30 March 2013 from http://pulsemagazine.org/Archive_Index.cfm?content_id=70.

by movements and thunderings greater
by far than my hand's grasp;
and for their final victory,
I apologize

In reflecting on this poem, Wu states, "I wrote this poem when confronting my aged father-in-law's slowly declining health. I am a family doctor – not his – but I certainly felt helpless in the face of his inexorable illness." Her father-in-law's illness caused Wu to 'confront' the limits of her own knowledge, the edge of her abilities and their uncertain futures.

In the following piece "Illness as Muse", Campo (2011) describes an ongoing relationship with a patient as well as an ongoing dialogue with himself as he struggles to reconcile the internalized voices of two competing narratives – that of biomedicine and a more relational voice which seeks to understand the patient's story. He evokes how intertwined these two narratives are and how this internal dialogue plays out during one difficult clinical interaction.

Story: A cold bitter wind

Of course, the next morning always comes and I find myself in my clinic again, the exam room speaking aloud in all of its blatant metaphors – the huge clock above where my patients sit implacably measuring lifetimes; the space itself narrow and compressed as a sonnet – and immediately I'm back to thinking about writing. Soon enough, my patients start to arrive, and the way they want me to understand what they are feeling only immerses me more deeply in language's compelling alchemy: "The pain is like a cold, bitter wind blowing through my womb," murmurs a young infertile woman from Guatemala with what I have diagnosed much less eloquently as chronic pelvic pain. "Please, doctor, can you heal me?" I regard her from across the desk, and feel grateful for the computer terminal more immediately in front of me, which allows me to type a little medical jargon into my note before having to actually speak to her. "Send her for an exploratory laparoscopy," growls Susan Sontag in the back of my mind, but she's already had that procedure, along with several ultrasounds and pap smears, innumerable blood and urine tests, a hysterosalpingogram, a colonoscopy, and a trial (ironically) of birth control pills...

We have had this conversation before, which I realize is another way of saying we are together part of a narrative, a story. A story in which irony matters, in which understanding metaphor – might her pain be a wordless expression of her deep sadness at her inability to have a child, or perhaps the consequence of some trauma she has not disclosed? – seems to have some irrefutable value. Now, I am thinking again about writing, but not a prescription for the pain medication she always refuses; instead, I am

> thinking about writing a poem like Sharon Olds. I am thinking about the metal speculum clattering in the sink while she sobbed softly after I performed her last pap smear, as if it were trying to reiterate something about coldness and bitterness, or what we hear and can't hear, or pain and abjection.[60]

In reflecting on his interactions with this patient, Campo is struggling with the limits of his own role as well as acknowledging his part in the construction of her unfolding 'illness narrative' ("we are together part of a narrative"). While trying to attend to the biomedical needs of his patient, Campo reflects on the dilemma of further testing and medical treatments (acknowledging their probable futility), while at the same time pondering what other meanings may be attached to her chronic pain and infertility.

This piece illustrates a search for what Engel et al (2008) calls the 'lived experience that provides context and meaning to clinical diagnosis and treatment'. This story can also be read as Campo's acknowledgement of the limits of what he can offer. Engaging in what feel like futile tests, Campo confronts his own doubts and uncertainties and the (im)possibility of a cure. Caught between the professional imperative to "assess and treat", and his awareness of her continued suffering, Campo is asking questions about the morality of continued medical interventions inviting us to ask 'what is good medicine'?

Notions of time and space are present in this piece – the exam room they meet in is "narrow and compressed" and their conversation is dominated by "the huge clock above where my patients sit implacably measuring lifetimes" emphasizing that time unfolds differently in clinical interactions. In contrast to the certainty of biomedical discourses and pre-planned treatment scripts that anticipate a clear and definitive ending, clinical interactions unfold in 'narrative time' and are characterized by uncertainty (Mattingly, 1998). This 'unfolding story', with its unknown ending, renders the practitioners (and patients) vulnerable to an unknown future as "if lived experience positions us in a fluid space between a past and a future, then what we experience is strongly marked by the possible. Meaning itself, from this perspective, is always in suspense" (96).

There are many internal voices woven into this narrative – the voice of biomedicine, the voice of writer Susan Sontag (who argues that illness is *not* a metaphor), and the voice of poet Sharon Olds who writes so evocatively on issues of illness and other "unpoetic life events."[61] Campo expresses the dance of connection and disconnection in such moments in practice as he writes, "I regard her from across the desk, and feel grateful for the computer

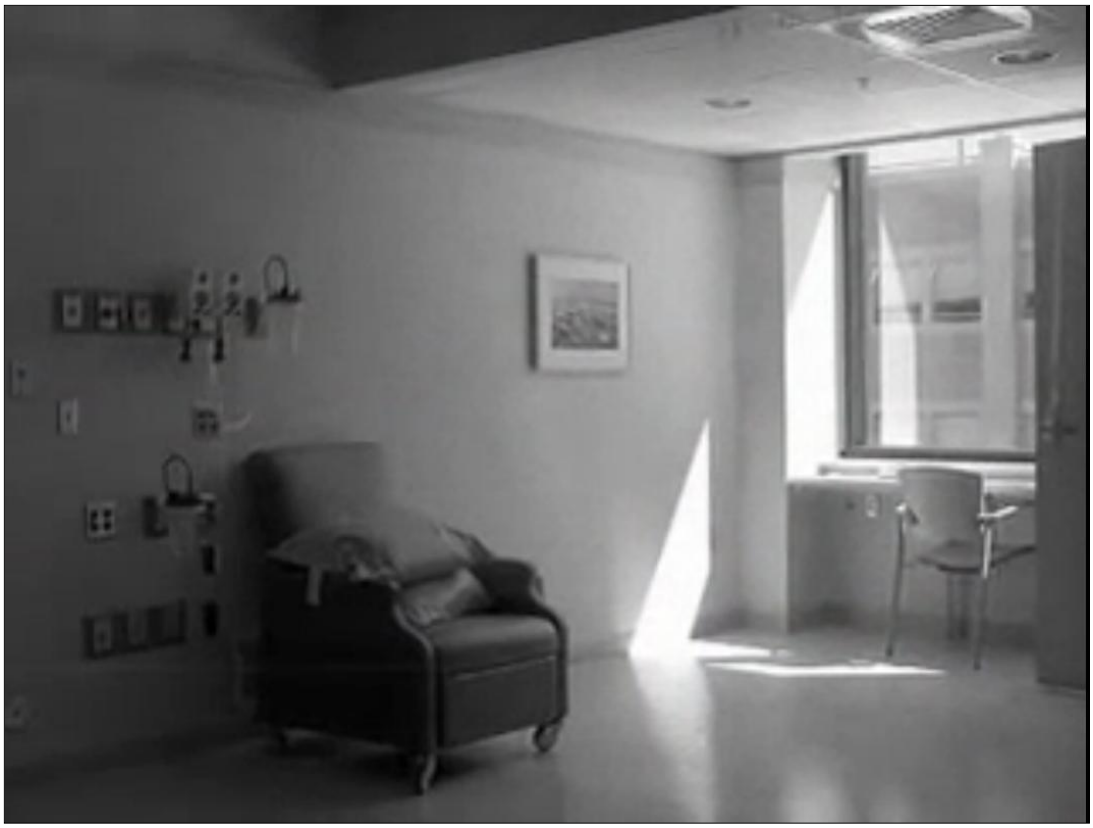
---

[60] Accessed 30 March 2013 from http://poems.com/special_features/prose/essay_campo.php.

[61] Sharon Olds is a prolific American poet well known for her accessible writing style as well as her frank treatment of taboo subjects such as domestic violence, sexuality, and illness. For more information on her poetry see www.poetryfoundation.org.

terminal more immediately in front of me, which allows me to type a little medical jargon into my note before having to actually speak to her". Even before the patient leaves his exam room, Campo is thinking about how to 'story' this visit – and how to do justice to the complex interweaving of narratives and relationships that filled the room.

What we carry



A patient's presence before us in a hospital or office setting becomes for us a moral occasion, a measure of our moral life as it is lived moment to moment.

Robert Coles, 2002

As every [practitioner] does throughout a career, I presume, I carry certain patients with me, in the pockets of my white coat.

Joseph Zarconi[62]

[62] in Engel et al, 2008: 15.

In the iconic short story, "The Things They Carried", author Tim O'Brien describes a group of soldiers marching through Vietnam describing the items that each soldier carries. Tangible items include maps, compasses, food, machinery and other necessities for survival; but it is the 'intangible' things they carry that beats at the heart of this story. O'Brien writes, "they carried the sky. The whole atmosphere... they carried gravity... grief, terror, love, longing – these were intangibles, but the intangibles had their own mass and specific gravity, they had tangible weight". The weight of these intangibles is conveyed by O'Brien as he writes about the presence of the soldiers' memories, hopes, grief and fears. As Jason Voegele writes in his commentary on the story, "the weight of these abstract items is as real as that of any physical ones, and unlike those physical objects, they are not so easily cast away."[63]

While ideologies of professionalism in healthcare perpetuate the idea that practitioners are unaffected by their encounters with patients, like O'Brien's soldiers I suggest that healthcare providers carry 'intangibles' with them as well. While healthcare practitioners are typically schooled in the 'space of detached concern" in which they keep their patients at a distance, and "decline to connect with them in other than superficial ways" (Engel et al, 2008: 226), some writers challenge this detached stance.

Sally Denshire and Susan Ryan (2001), for example, critically examine the implications of the natural science paradigm on notions of professional identity and role – in particular the assumption that the work is 'value-free' and 'context-free'. Instead, they suggest that "it is impossible to separate our personal lives from our professional lives". Ultimately they advocate an approach to practice that acknowledges the 'personal-in-the-professional' and the 'professional-in-the-personal' (150). Philosopher and medical educator Craig Irvine has suggested a different conception of practice rooted in more narrative and relational sensibilities, urging us to think about our day-to-day work as an 'ethical practice that acknowledges we are all "contingent beings – affected by all we encounter in the world".[64]

This echoes Michael White's (2010) description of a 'two way account' of practice that emphasizes the "life-shaping nature of our work in respect to our own lives' as practitioners" (130). This way of understanding professional relationships challenges the hierarchy of knowledge between practitioner and patient, and is grounded in a sense of reciprocity that "acknowledges and honours the contribution of persons' knowledges and skills to the work and life of the practitioner" (131). While this may constitute a transgression of the conventional work/life boundary, White suggests that a two-way

[63] Accessed 30 March 2013 from www.jvoegele.com/essays/things.html.

[64] Narrative Medicine Workshop, Columbia University, June 2011.

account of professional practice can engage practitioners in acts of meaning that contribute to richer understandings of professional identity.

Rather than viewing ourselves and each other as disembodied and temporary 'visitors' at our places of work, narrative writing by practitioners can help construct an alternative narrative of practice – one in which we recognize "the mutual influence that practitioners and patients have on one another" (Engel et al, 2008). Practitioner narrative writing is filled with "contingent beings" who do not "leave themselves behind" when entering their therapy offices or clinical settings. In this sense, narrative writing provides a place to consider the questions posed by Howard Stein (2011) in his poem "What to do with it?" excerpted here:

Poem: What to do with it?

"So what do I do with it
With the fact that all this
Happened?"
...There is no going back
To who I was and to what

I agree with Stein that 'there is no going back to who and what we were'; that we are affected by what we see and experience. Other practitioner/writers reflect on the ideologies of professional training that cultivate a distancing from patients and a detached disembodied professional identity. Discussing his training in psychiatry, for example, Robert Coles (1989) remembers the advice given by his supervisors, to maintain a certain 'hovering distance' from patients. Noting that the achievement of hovering distance was seen to represent the pinnacle of professional maturity and competence in psychiatry, he also remembers explicit warnings against getting 'too involved' with patients – as 'that phrase was a mainstay of our daily intercourse as residents' (9). In reflecting on how this training in disconnection was not useful for patients or himself, Coles recalls challenging that ideology of practice with a particular patient who invites him into a different relational stance by stating, "You tell me your story, and I'll tell you mine" (16).

Nurse and clinical ethicist Susan MacRae (2010) explores similar terrain as she reflects on the pervasive messages she received as a nursing student to *not get so attached* to her patients. In the personal essay "To Be Humans with other Humans" she discusses what initially drew her to become a nurse, while acknowledging that she was ill-prepared for the relational realities of practice. "Nothing could have prepared me for the actual experience of relationship that I encountered once I entered the clinical years".

Story: To Be Humans with Other Humans (excerpt)

> As my training progressed, I noticed more about relationships. My relational contact seemed to circle around medications, equipment, laundry, schedules, staff availability and incidents of one form or another... I learned I had no clue how to be a good caregiver or how to navigate these relationships in this context. So I watched and listened to those around me for guidance... shortly after [my] patient died, [a resident] brought me into the coffee room for a few moments before his 'code' beeper went off again. 'Don't let them get to you', he said. He touched me briefly on the right shoulder, almost connecting but not quite, spun around and left me under the fluorescent lights in a room smelling of burnt coffee...
>
> Don't let them get to you? It seemed like bizarre advice under the circumstances.
>
> When I arrived home my father asked, 'how was your work last night honey?' I stood at the bottom of the stairs before heading for the dark basement where I would block out the light of the sun so I could fool my body into thinking it was night time. That morning, I was aware for the first time of the gap that existed between those of us who do this kind of work, and those of us who don't. It was also the moment that I began to realize the amount of distress, pain and intense suffering that I was being asked to bear and endure in my role as caregiver. (MacRae in McLean, 2010: 289)

MacRae reflects on her professional training to examine the potential for narrative to challenge the 'oppressive flatland and scientific efficiency that still defines healthcare despite many knowing that caregiving is an endeavour of human capacity' (in McLean, 2010: 287). Her story is part of a larger project exploring 'personal experience and meaning making', and is an attempt to bridge the 'intense isolation' of clinical practice.

Her story speaks eloquently to the many kinds of disconnections in professional practice contexts – between practitioner and patient, between practitioners, and between our professional and personal worlds. She recounts her relationships with different patients, reflecting that there was no time for peer discussions about the emotional and spiritual challenges that were a regular part of this work. "Instead I was told by my colleagues not to take things personally. I was told not to be weak. I was told not to be so sensitive and emotional. I was told, 'Don't let them get to you'. But what if they did? And they did. Then what?"(MacRae in McLean, 2010: 292).

MacRae's story reminds me of a poem by medical social worker and poet Glen Downie (1999) from the series appropriately called "Learning Curve Journal – Orientation".

Poem: Learning Curves (excerpt)

They introduce you to the water
by throwing you
in the deep end

Welcome to the life
Welcome to the work

A near-death experience
followed by another
& another
& another
& another…

The realities of practice come as a shock in Downie's poetry as he describes being "thrown into the deep end", echoing MacRae's sense of moral abandonment as she describes "falling without anyone to catch me". MacRae begins to write stories about her practice to "write herself back into the meaning of her work" (293), and as a way to challenge the prevailing discourses of distance and disconnection. Thinking about the profoundly inadequate advice she received, she states "we need to find better advice for our colleagues than *'don't let them get to you"*. Her story is a call to do better; and the story itself provides a narrative that acknowledges the real impact of our work.

Nurse Cortney Davis uses poetry to highlight the everyday connections and losses involved in caregiving. She writes about her relationship with patients, but more importantly, she writes about how those relationships stay with her. "Some go home, cured and we celebrate their leaving; others die, and we remember them" (Schaefer, 2006: 23). In her poem "The Nurse's Pockets" she evokes a sense of the intangible, yet powerful, things we carry in this meditation on memory and loss.

Poem: The Nurse's Pockets

When patients are told they're dying
They say something simple;
I've had a good life or Who will feed my cats?
It seems harder on the doctor
he waits outside the door, stalling,
until the patient confronts him.
So Doc, they say, What's the verdict?

Soon, a nurse comes to bathe the patient.
There is only the sound of water
wrung from the warm washcloth,
the smell of yellow soap,
and the way she spends time praising
the valley of his clavicle, his hollow mouth.

Then, a morning when the patient leaves,
taking his body. The nurse finds nothing
but the bed with its depression,
its map of sheets she strips.
In the drawer, gumdrops. A comb
woven with light hair, and a book
with certain pages marked.

She takes all these into her pockets.
She has trunks in every room of her home,
full of such ordinary things.

The poem conjures the physical intimacies, memories and losses of nursing practice. Placing patients' items in trunks that 'fill every room of her home' is a tangible way of bringing her patients (and their stories) home with her. Davis writes about the poem, "Perhaps all those trunks are like poems. Whenever she wants, she can open one up and recall, from those ordinary things, the unique life of each individual patient… We remember our patients" (in Schaefer, 2006: 24).

Poet and psychotherapist Ronna Bloom (2000) expresses the visceral impact of hearing other people's stories in the poem "Personal Effects" suggesting that these stories become part of our inner dialogue and stay with us as haunted memories that become our own. She writes, "people will tell you if you listen / If they can. / Then every time you pass there, every single time / you'll be haunted by something / that never happened / to you. But hearing it becomes yours."

Similar to writing that challenges the notion of autonomous and disembodied practitioners, other writing challenges the (false) dichotomy between the personal and the professional. By reconceptualizing what it means to be a professional, the boundary between the 'personal' and the 'professional' is re-drawn. Physician Rafael Campo recalls being taught to ignore the role of "sticky psychosocial issues" in medical care, and describes having to keep his distance from patients after a negative evaluation from a supervisor said he had 'identified too strongly' with his patients. Deciding to keep any issues related to his own identity or personal history to himself he states, "I was relearning the correct and appropriate use of silence" (Campo,1997: 130).

Cortney Davis reflects on the assumed separation of work life and personal life early in her career: "I never wrote about nursing. What I did in my professional life seemed out of bounds, too clinical, too separate from my 'other' life... " (Schaefer, 2006: 22). A shift in how she understands the relationship between the personal and the professional came with the death of one of her patients.

> Toby died. There were three of us at her bedside: me, her doctor and a respiratory therapist. For months, I couldn't get the image of Toby, dying, out of my mind. I didn't know what to do with my grief, a loss I couldn't, it seemed, share with anyone. After all, patients died every day. And, as another nurse reminded me, Toby hadn't been, not really, a personal friend. But the loss I felt was palpable. Faced once again with the task of making sense of the pain of separation, I wrote a poem about Toby. (Schaefer, 2006: 23)

The practices that divide professional and clinical relationships from (so called) "personal" relationships like friendships, denies the permeability of these boundaries as well as their power. The idea that we are moved by the stories of our clients – and that these stories can change who we are by imprinting themselves upon us – undermines assumptions about the need for distant and disconnected practitioners. Some writers have challenged these notions, arguing that "our autobiographies as practitioners, teachers and clients represent some of the most important sources of insight into practice to which we have access" (Higgs 2008: 69).

In the following story, one of Rita Charon's students expresses the connection between personal history and professional role within a brief moment in practice. He evokes the impact of a significant personal loss (the death of his grandmother), the anniversary of September 11 and the fears that provide the "back story" to his interactions with this particular patient.

Story: Mrs. V

> One of the hardest days of my med school experience, the second anniversary of Sept. 11, on which I was isolated from the friends I needed and compelled to work an 18-hour shift, I fell in love with a very special new patient. Pleasant and fun, never complaining even when she described symptoms that would send other people into a constant fit, Mrs. V. possessed a rare charm and appreciation of human kindness that reminded me of my very dear and deceased grandmother. I hated the first 11 hours of that workday, because I was compelled to work on the demands of the here and now, rather than find the space I needed to reflect on the past. Yet, in the final 7 hours of that burdensome day, meeting and working with Mrs. V. gave me something to look forward to and cherish, rather than regret. I would relish every subsequent morning when I could tap her door – though she wouldn't hear the tap – stride into her room happily, and sing a large, gentle, "good

morning, Mrs. V." Quickly answered, no matter her pains, with an equally enthusiastic, "Good morning, George!"

Mrs. V., who came to us because of severe back pain and blood in the urine, asked me several days later whether she had cancer. Based on our most recent test results at the time, cancer was one of the possible causes of the symptoms. I didn't want to worry my patient with the possibility of cancer, though it made me nervous. I told her that I didn't think she had cancer, but that it was one of the things we would look for and rule out in subsequent tests. I may have even told her to let us worry about it for her. She was pleased.[65]

In this short story, the medical student expresses the weight of personal and social losses that often inform clinical interactions, as well as the importance of his brief relationship with this patient. Even his use of the evocative phrase, "I fell in love with a very special new patient" signals an intimate connection not usually associated with students or healthcare practitioners and their patients. This story challenges the notion of a depersonalized anonymous doctor (and patient) and makes clear his real concern for her. In the writing of this story he continues to honour the impact of their brief encounters and offers us an account of what lies outside the official record.

The short story "Chalcedonies", by physician Jeff Nisker, evokes the complex and delicate interweaving of connection and disconnection in clinical encounters. It also closely parallels the dilemmas raised in my relationship with Angela (see story in Section I) about acts of naming and the fraught demarcation between the personal and the professional. Nisker describes this story as "a work of fiction, built on true occurrences in the life of this woman and my 'sound bite' relationship with her" (Nisker 2010: 418).

Reflecting on the writing of this piece in a subsequent article, Nisker (2010) discusses the delicate relationship between fact and fiction. Commenting on the fact that his former patient wanted him to write a play about her "to bring attention to a broken system that could be beautiful" he decides not to use her real name "so as not to conflate fiction with fact, or presume more insight into her lived experience than I could possibly possess" (418).

Nisker's (2008) story begins with the meeting between a doctor and a patient in an emergency room and follows the unfolding of their unusual relationship during the patient's brief stay in the hospital. As readers, we are witness to the shift in how the doctor views this patient – and how she moves in his eyes from a passive sick patient to a whole person suffering with a serious medical condition.

---

[65] From *Stories in Medicine* on NPR. Accessed 30 March 2013 www.npr.org/templates/story/story.php?storyId=1480863

Story: Chalcedonies (excerpt)

> Perhaps it was her eloquent tranquility that spoke to me through dishevelled hair and down-drawn drinking straw lips. Perhaps it was her eyes... whatever it was, I prescribed my human presence to distract her from an evening of loneliness or pain. This was not altruism; I knew I would receive more than I could return. The next evening I visited the patient, for a patient Janice still was to me, IV inserted, hospital-gowned, hospital-bedded.
>
> I asked her permission to visit, not as a physician, but as a person: a person who would like to know her as a person, who would learn from her, who would gratefully reciprocate whatever she chose to share. I knew the doctor-patient differential defies dissolution, but I also sensed that Janice, for she was now Janice, possessed the strength to order my dissolve... the next night, before she was surrounded by a hundred students, I asked Janice's permission to introduce her as my friend, rather than as the patient she portrayed, immersed in a wheelchair with a half-filled catheter bag. I wanted to insist that they saw Janice as person, not a patient; a friend, not a phenomenon. She agreed. (Nisker, 2008: 173)

By introducing Janice as a friend, Nisker rejects practices that inadvertently depersonalize patients and participates in a radical act of naming. We see not only a shift in language, but in the framing of the relationship. Through his naming practice, Nisker demands that others recognize her subjectivity as well as the personal connection between them. Finally, in sharing this account of 'Janice', Nisker draws us all further into the story, making explicit his hope that the story be used to promote more compassionate practices. "Janice taught me to be more compassionate, and to try harder to catalyse compassion in others... I hope she will continue to teach me, to teach us all, to be my friend, to be a friend to you".

The encounter shifts to a moment of mutuality – recognizing the differing situations and perspectives of each person while recognizing the full humanity of each. This is in line with Cissna and Anderson's (1998: 69) ideas about 'dialogic moments' and their suggestion that mutuality is not a permanent state, but rather something that occurs in brief moments.

> Mutuality should not be confused with equality – no relationship exhibits complete equality. At any moment, one person or another is always, for example, somewhat more knowing or more vulnerable or more powerful, perhaps as a result of roles... mutuality [is] where we do something together which neither of us can do separately. Although reciprocity is useful, it is mutuality... that allows us to 'become even more fully human'.

In her memoir *The Making of a Nurse* Tilda Shalof provides another glimpse of the sometimes tenuous line between professional caring and personal friendship. In telling the

story of an intensive care patient named Evelyn, we see how Shalof attempts to navigate the tension between her personal and professional worlds. Drawing on her own experiences caring for an ailing mother, Shalof reflects on the close bond that developed between her and the patient's daughter, reflecting on how "false it would have felt to stay within the limitations of my strictly professional role with this family. How much I would have missed! I was responding to them as personally as I was professionally" (2007: 141).

Shalof discusses her efforts to find a balance between being overwhelmed by the emotional toll of nursing, and her commitment to providing compassionate care while maintaining a "dispassionate stance". She reflects on her ability, after many years of practice, to take her 'professional mask' on and off as needed. "I had to learn how to safely enter a patient's world and still keep mine intact… I spent many years searching for my way of being a nurse. It's only been in recent years that I've learned how to take off my mask and not strip off my entire uniform along with it" (2007: 134-7).

Echoing Shalof's attempts to honour these connections in our work, Campo also explores the sometimes intimate relationships with his patients. He describes a 'loving friendship' with his patient Mary that moves beyond the strict roles of doctor and patient. Well aware of the possible transgression of professionalism signalled by such relationships, he tries to provide an honest accounting of their connection as well as this act of boundary 'crossing'.

Story: 'Mary' and 'Aurora'

> Each morning I would visit Mary during my rounds. Our encounters were always preceded by my ritualistic hand washing... I imagined at times that I was visiting a secret love, so much urgency did I feel in her desire to live. We spoke in hushed tones, hardly a word about the progress of her cell counts, more and more about silly, temporary things like our favorite Chinese restaurants, how much we owed in parking tickets, the nurse's new butch haircut. On and on, like teenagers in a booth at a soda fountain. When I'd leave, I feared during the long hours I was away from her that I might never see her again... so we loved each other in the ways that we could. We listened to each other attentively and held hands. I write about her now, and she is alive. Constrained as we were by our respective worldly roles, as doctor and patient, gay Latino man and straight white woman, still we found the space to make a very particular kind of love... both Mary and I left our loving friendship healthier, I think, closer to being cured... I remain fearful for the future of this sort of honesty. The so-called personal lives of physicians and patients – as if the organs of emotion could be so carefully dissected in such an acute relationship – are already the subject of a scrutiny that seeks to eradicate the possibility of human connections. (Campo, 1997: 26)

Talking about his time as a medical intern in San Francisco during of the height of the 1980s AIDS crisis, Campo shares a story about another patient who he calls 'Aurora'. Describing her as a preoperative male-to-female transsexual who is admitted to the hospital with complications from AIDS, Campo acknowledges that his own fears and anxieties have a distancing effect. In reflecting on one of their last encounters, Campo (1997) experiences a profound sense of loss at her impending death and a desire to acknowledge her effect on him – how to "carry an element of herself in me".

> When I rolled her over, seeing her face stripped of all her glittery make up, expressing not recognition but a deeply subterraneous pain, a primitive and wordless agony, finally I was moved... I was witnessing the loss of love from the world.... Aurora died later that day, and when she died she left behind an element of herself in me. I find her voice in mine... her friendship and her love of life return to the world in these words, in the poems I write that I hope might ascend to reach her in whatever realm she may now exist. Instead of giving me AIDS, as I had so irrationally feared, she gave me hope (32).

Campo's writing explores the complex, and often unarticulated, relational landscape of practice. By 'interrupting stereotyped relationships' and notions of professionals and patients (Lindsay, 2008: 24), he challenges the disconnect between the personal and the professional. In questioning the idea that to be a good doctor means to embrace 'immunity', or be unaffected by the suffering of others, Campo's writings reinforce the role of 'personal knowing' and 'lived experience' as a legitimate source of professional identity and knowledge (Lindsay, 2008: 21). In reflecting critically on his relationships with patients, and challenging how he was trained to act, Campo is no longer "alienated by the otherness of his patients" (Frank, 2004: 91).

The notion that 'who you are as a person is who you are as a nurse,' articulated by nursing educator and scholar Gail Lindsay (2008), is explored in a different way in the poem "Semi-Private Room" by Jan Jehner.[66] In asking us to imagine the possibility of more relational responsive clinical interactions, Jehner examines a brief moment of contact between a nurse, a patient, and her family.

[66] Accessed 30 March 2013 http://pulsemagazine.org/Archive_Index.cfm?content_id=152.

Poem: Semi-Private Room

Sometimes nectar appears
when stories intersect:

I walk into the room
rearrange the bed-table
and push the pole with its bulging bladder sideways
for a closer look.

Her thinness triples the size of the bed
but her father, with his anxious chatter
feels strangely like my own
and her resolve, that tense control
has a familiar edge.

It feels like all the calories she's ever counted
and all the sweet things resisted for the last eleven years
have aligned as a taut shield
protecting that juicy place that hasn't ripened,
urged too early to carry her family through chaos:
after all, her mother was dying of cancer
after all, mine couldn't manage mental illness
after all, aren't fathers helpless in these things?

The electrolyte imbalance that nearly took her life
and the nurturance imbalance that emptied
her adolescent pockets of all the in-free tickets,
lie tangled with the feeding tube she never wanted
while she talks and I listen, my beeper ignored.

Our connection becomes a spoon
with its delicate curve
Starting the good-byes, I hand her my card
she reads through the menu
departing, I feel the full moon
rising in my chest.

In this poem Jahner evokes the complex interweaving of the personal and the professional; exploring the subtle, yet powerful, connections between caregivers and patients. With the evocative opening lines 'sometimes nectar appears / when stories

intersect' we glimpse the entwining between her story and her patient's. The patient's father reminds her 'strangely' of her own, the patient's 'resolve and tense control' reminds her of herself, and the patient's burden of her mother's illness echoes her own experience with her mother's mental illness. The two stories intersect in ways that create a tentative opening – described as 'a spoon with a delicate curve.'

These relational resonances are recognized by a reader who responded to Jahner's poem on the pulse magazine blog. Identifying herself as a pre-med student, and as someone who struggled for years with an eating disorder, she writes: "thank you for what I'm sure you did for your patient that day, and for sharing your experience with all of us. I admire the way that you have obviously turned your own struggles and weaknesses into bridges to your patients."

Even the title "Semi-Private Room", which refers to a hospital room shared by two patients, highlights that there are potentially two people present in the room, and makes possible a genuine connection between patient and nurse. The possibilities for even further resonance are suggested in the author's statement: "Most of my poems emerge from the specific residue of a clinical encounter that wants more time and attention. I enjoy sorting out the interconnected elements of the parallel process involved in giving and receiving care. The young woman in this poem hoped to become a nurse." As the student (above) recognized, Jahner was able to use her own experience as a bridge to that of her patient – suggesting a more nuanced view of the relationship between the personal and the professional.

Questioning the narrow cultural discourses related to professionalism, McNamee states that "being the expert, is so sedimented, so fixed, that we find people acting as they imagine they should act if they were a professional, and completely ignoring some of the most useful resources they might have – resources that allow them to be fully present in conversation with the client" (in Guanaes and Rasera, 2006). Encouraging us to think differently about what 'resources' we bring to our professional practice, McNamee encourages us to draw from skills and knowledge learned in other contexts – or 'using familiar resources in unfamiliar places'. In this sense, knowledge gained from personal experience can be seen as a valuable resource for practice.

In the next section I turn to an examination of the implications of narrative in health professional education. Through a discussion of my own teaching experiences, I explore the capacity of poetry to engage us in (re)thinking the relationship of the personal and the professional, and to create space for both relational teaching and a critical consideration of the relational ethics of everyday practice.

5. Implications and final reflections

so much depends
upon

a red wheel
barrow

glazed with rain
water

beside the white
chickens.[67]

I lean in through language; I distance myself through language; I negotiate meaning through language. In short, I language my way into being as a social being.

Ronald Pelias: 2011: 17

---

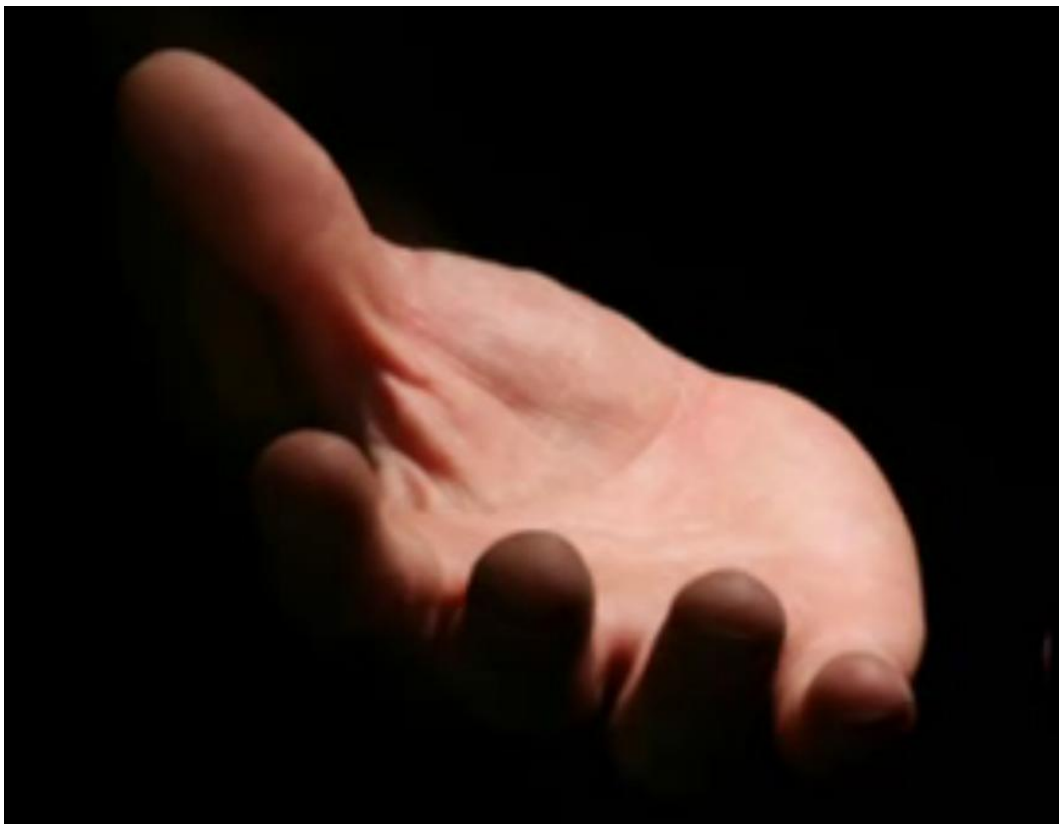
[67] *The Red Wheelbarrow* by William Carlos Williams. Accessed 30 March 2013 from www.writing.upenn.edu/~afilreis/88/wcw-red-wheel.html.

Overview

In the final chapter, I explore the use of narrative in education and, in particular, its role in calling attention to tensions in professional practice. As an example of the opportunity that narrative offers in reflecting on practice, I draw on my experience as an educator to discuss the use of narratives in critically examining our notions about practice ethics. I discuss my experience in using poetry to reflect on issues of professionalism and the relational complexities of practice. Drawing on ideas about relational teaching practices, which view teaching as a conversation, I discuss the role of narrative in creating space for collaborative meaning-making. Poetry can thus be viewed as a way to 'see differently', and offers us a way to resist dominant conceptualizations of professional practice identity.

In the final section of this chapter, I reflect on my thesis inquiry journey through the lens of narrative inquiry and the possibility of using narrative to generate different kinds of conversations in healthcare. In wanting to promote an inclusive approach to inquiry, I offer an example of how we can integrate personal narratives with other forms of social science research to provide multi-dimensional accounts of everyday practice. In a kind of 'double reflection', I reflect on the role of narrative in building a 'preferred future' or counter-story for healthcare practitioners which acknowledges the uncertainty, ambiguity and mutuality of practice.

Acts of resistance: poetry, education and practice ethics



Ethics are carried by what connects people; that which is between us, for instance, language and conversations.

Tom Andersen[68]

If education is anything it is storytelling... at its most fundamental level, teaching is about the negotiation of a series of relationships. Or expressed slightly differently: it occurs in the unfolding of a set of inter-related stories... It is in story telling, to ourselves and to each other as colleagues and with and to our students, that we learn to navigate beyond the generic concepts of either teacher or learner.

Marcus O'Donnell[69]

---

[68] From an interview in *New Therapist* magazine. Accessed 30 March 2013 from www.newtherapist.com/andersen5.html.

Informed by the idea that narratives are useful adjuncts to conventional scholarship (Goldstein, 1993), I have looked for ways to incorporate narrative into my practice as a classroom-based teacher, social work field instructor, and hospital-based clinical educator. This began several years ago when I introduced memoirs written by people who had struggled with health and mental health problems into a social work course I was teaching to 'complement' the academic literature. I incorporated personal narrative, through memoir writing, as an alternative to clinical and professional discourses and a way to understand the 'lived experiences' of clients and the value of a more everyday language of practice.

More recently, I turned my attention to the use of narrative reading and writing in hospital-based seminars for students on hospital placements. Using personal narratives by patients and practitioners, short stories and poetry as learning resources, I have tried to create opportunities for reflection and dialogue on practice. Poetry has proven an effective way to expose students to both rich descriptions of practice, and provide an entry to discussions on the relational dimensions of practice.

Journalist professor Marcus O'Donnell points out the connection between the "spatial turn" in social science discourses (i.e., the use of terms such as 'borders', 'maps' and 'space') and the development of a critical pedagogy which values conversation, connection and collaborative meaning making.[70] If getting to know a poem is like "entering a relationship" (Hirshfield, 1997: 48), then it seems fitting to contextualize the use poetry in health professional education through the lens of relational teaching practices.

The importance of the arts and narrative in promoting critical reflection on issues of ethics and professionalism has been well documented (Balen & White, 2007; Kinsella, 2006; Loughran, 2002; Heath, 1998; Schon, 1987). Poetry is one way to expose students to rich descriptions of practice, from both client and practitioner perspectives. Poetry is an evocative way to explore ethical dilemmas as it can promote empathy, encourage critical reflection and enhance our ability to respond to the multi-layered relationships of personal and professional stories within everyday practice.

As well poetry can call attention to otherwise unacknowledged tensions in health professional practice and discourse (Nisker 2009; Butler-Kisber 2010; Kinsella 2006; Bolton, 2005). In the article 'Narrative Social Work', Roscoe et al (2011) explore the unspoken, implicit assumptions behind social work practice and warn against the increasing 'routinization' of professional practice. Suggesting that narrative approaches can encourage engagement, creativity and interpretation (Roscoe), narrative reading and writing provides

---

[69] Accessed 30 March 2013 from http://marcusodonnell.com/teaching/philosophy.htm.

[70] Accessed 5 April 2013 from http://marcusodonnell.com/teaching/conversation.htm.

an opportunity for thoughtful reflection, and could inform a model of practice rooted in the everyday realities of practitioners and clients.

In moving away from an instrumental approach to teaching and learning, poetry can be an important resource for relational teaching practices. McNamee (2007) suggests that we think about teaching "as conversation'. This requires a critical perspective on dominant individualist ideologies of teaching which views teaching as the 'transmission' of knowledge from one person to another and perpetuates unexamined assumptions about the 'expert' role of professionals (and educators).

> I would like to propose, therefore, that we bracket the metaphor of teaching as a technique or method for conveying knowledge and consider the potentials opened by approaching teaching as a form of collaborative conversation... a relational approach to education requires that we abandon the idea that knowledge or information can be conveyed from one mind to another and, instead, I will describe knowledge as constructed in our conjoint activities with others – in what people do together. (McNamee, 2007: 314)

From a more collaborative standpoint, teaching and learning are viewed as meaning-making processes and emerge only in interaction with each other; in other words, knowledge emerges out of what people do together in the 'interactive moment'. This implies a more embodied approach to education as we focus on the 'visceral ways in which we move others, and are moved by them' in conversation (McNamee, 2007). Speaking of teaching as a kind of "relational performance", she suggests that teaching should be seen as a joint activity where new resources for action emerge. This perspective poses a question for educators: "How can we engage in the activity of "teaching" so that we approach it as a form of practice – an activity and a conversation – rather than a technique for conveying knowledge?"(McNamee, 2007: 317).

Viewing teaching as a conversation opens up possibilities for attending to the relational dimensions of our practice as it focuses attention to what is unfolding in the moment. This allows both educators and students to bring their experiences into the room and incorporate their experiences into the discussion as 'conversational resources'. As McNamee points out, when we conceptualize teaching as a relational phenomenon (i.e., as a conversation), we attend to different aspects of teaching: "Specifically, our attention is drawn toward the "process" of teaching... and the wide array of both common and diverse voices, relations, communities, and experiences that each participant brings to the current learning context" (McNamee, 2007: 319).

A relational approach to teaching positions educators differently. Rather than content expert, the primary role of an educator becomes one of facilitator as the task is to create spaces in which multiple voices to be heard. With the metaphor of teaching as conversation,

the expertise of the educator "becomes his or her ability to 'keep the conversation going' in Wittgenstein's sense"(McNamee, 2007: 324). If we understand the role of language in constructing meaning, then the central question becomes "what can we 'do' differently when we talk of teaching as conversation? It is important to note that the transition to a conversational and 'performative' metaphor positions the teacher differently than any of the individualist metaphors upon which we currently draw" (McNamee, 2007: 328).

Narrative can play a role in 'keeping the conversation going' by avoiding abstract principles and privileging storytelling forms. This blurs the boundary between the classroom and everyday life and draws our attention to 'language, stories, and relationships' through the teaching metaphors of joint action, performance and improvisation to guide our teaching practices (McNamee, 2007).

In a discussion on the importance of narrative and reflection in professional training, Goodfellow et al (2001) conceptualize learning as a reflective relational process suggesting that "personal practical knowledge requires reflective thought in and about practice rather than a process of direct transmission of information"(162). Acknowledging that learning seldom occurs in isolation, they suggest we approach professional education as a kind of "relational knowing" to be gained through interpersonal relationships. Recognizing that we "impart a bit of ourselves in establishing responsive learning relationships, they suggest the idea of 'critical companionship' to describe the relationship between clinical educators and learners. This emphasizes the importance of relationships in the development of professional knowledge (172).

My approach to the use of narrative texts in clinical education is informed by the notion that stories create space for 'different conversations' (McNamee, 2007: 328) and create 'opportunities for resonances' (Denborough, 2011). My approach to seminar discussions is also informed by Tom Andersen's ideas about the role of reflective processes opening up 'conversational space'. The structure of these discussions has been influenced by reflective processes as articulated by narrative practitioner Michael White (2007) and John Shotter's (2010) ideas about the importance of resonance between reader and text. (See Section I for more on this approach).

The structure of these seminars typically involve: (1) poem or short story reading (2) discussion of our responses and how those resonances are contextualized in our own experiences and (3) discussion regarding possible implications for future practice. Starting with the text itself (What do you think this story/poem is about?), we move towards our own responses (What specific images or phrases resonate with you? What catches your attention?), to consideration of how this might affect future practice (What will you take away from this poem or discussion?).

In trying to shift from 'conceptual discussion to visceral illustration' (McNamee 2006), I discuss the use of the poem "Professionalism" by Anne Kinsella (2006) to create conversational space on ethics and professionalism in day-to-day practice. Kinsella's poetic account of a relationship with a client, provides a unique opportunity to explore unexamined ideas about ethics in professional practice, as well as reflect further on relational teaching practices.

Poem: Professionalism

I was too professional
Louise
To give you the gift
A carefully picked out
remembrance

Of the hours we'd spent
planning your death

Negotiating the
painful intimacies
of the end of your life
Every other day
for a year

You – reminding me of me
Friendship blooming
where it should not
How unprofessional
to allow you to creep into
my heart!

You – my patient
not my friend
Your body's disappointments I know of necessity
It is my job

I transgress by visiting
your family in the evening
on occasion
in emergencies

Your last Christmas
I keep the gift in my bottom drawer
guilty

You in your wheelchair
embarrassed to be seen by those
who knew you when you were beautiful
venture out with dark glasses, a scarf on your head, to buy
a treasure for me!

My professionalism
weighs heavily in my chest
as I ask your ghost for forgiveness

I was initially drawn to this poem as I recognized its power to invite students' reflections on practice dilemmas. "Professionalism" can be read as Kinsella's attempts to critically reflect on the invisible 'microethical moments'[71] defined by Frank (2004) as "an occasion when we must respond to another person, and the nature of that response declares our moral self and the values we uphold" (19-23). Written in a deeply personal voice, the poem explores a practitioner's struggles to navigate through the intimacies of caregiving, and the sometimes murky territory of 'professionalism'. The impact of her client's death invites us to think differently about personal/professional boundaries and professionalism – and how conventional discourses may fail us and our clients. In this way the poem asks unsettling questions about professionalism and professional identity; issues too often neglected in official curriculum on professional ethics (Nisker 2008).

The poem resonated with me on a more personal level as well as it evoked memories of my own relationship with 'Angela'.[72] In particular, the poem speaks to the struggles we had in negotiating the 'boundaries' of our relationship – our own dance of connection and disconnection. The poem also captures the sense of humility and 'not knowing' I experienced in the aftermath of Angela's death as I tried to make sense of my sense of loss as well as the meaning of our relationship. Most importantly, I had learned to say 'I don't know' or 'I'm not sure' when I didn't have an answer, rather than step into expert-driven discourses of certainty and authority.

Perhaps it is Kinsella's similar sense of humility and honesty, and her questioning and vulnerable voice, that most draws me to this piece. The poem expresses the sense of sadness and uncertainty she felt following Louise's death. Reading it evokes the same feelings that sat heavy with me after Angela's death as I was thrown into 'not knowing' territory – asking questions that were difficult, if not impossible, to answer (Gold, 2007). While writing also provided me with a way to 'make sense' of my experience, Kinsella's poem evokes my own

[71] Frank (2004) uses the term 'moral' (rather than ethical) to refer to those interpersonal moment-to-moment actions embedded in healthcare practice (19).

[72] See Section I for a fuller discussion of this relationship.

long standing doubts. In many ways, Kinsella's words "I was too professional Louise / To give you the gift / A carefully picked out remembrance / Of the hours we'd spent" spoke to my own sense of regret at missed opportunities and failures of connection.

In seminar discussions on this poem, students spoke about their emerging sense of professional identity, and their struggles to reconcile personal values and professional practice. Some students pointed out the disconnection between abstract notions of professionalism and the realities of day-to-day practice. When asked, "what strikes you about this poem?" certain phrases and images stood out: "My professionalism weighs heavily on my chest" and "I ask your ghost for forgiveness" had a visceral impact, as we were invited to consider how we let clients down, or how our assumptions about professionalism worked to maintain our distance.

Students responded strongly, as well, to the sense of betrayal suggested in the poem with comments like "it sounds like the writer feels she betrayed the client in some way." The idea that a practitioner would seek forgiveness from a client for staying *within* professional boundaries was an unsettling, yet provocative, notion. Students were struck by the powerful connection between them and the feelings of grief expressed in the poem over Louise's death. "How unprofessional / to allow you to creep into / my heart? / You – my patient / not my friend / Your body's disappointments I know of necessity / It is my job" resonates with the impact of the loss as well as the unhelpful dichotomy here of patient/friend.

This has led into discussions of the role of loss in professional practice and students have often acknowledged that they feel ill equipped to deal with this aspect of practice. The presence of our own experience of loss in professional practice has had little place in professionalized knowledge and practice theories. This, in turn, has lead into discussions of other neglected, silent (or liminal) places in training which remain unarticulated and unexplored. In many ways, this poem helps us make sense of the gap between "critical aspirations [of practitioner] and practice realities" (Rossiter, 2005).

Arguing that professional training does not prepare us for the complex demands of day-to-day practice – not does it challenge privileged professional discourses shaping our practice – social work professor Amy Rossiter explores what a "critical ethics of practice" would look like:

> In conventional social work education, practitioners are asked to believe that they will learn a theory, and then learn how to implement it. These theories

> contain values that are supposed to dovetail with practice... [but] [t]he failures of this fantasy cause us to suffer, to apologize, to despair.[73]

Wanting to move beyond "suffering, apology and despair", I also seek to use the poem as a jumping off point to consider our own understandings of professionalism and experiences in navigating these kinds of relational dilemmas in practice. Students have shared examples demonstrating the blurring of personal/professional lines and so called 'boundary violations' that they have witnessed or heard about. At times, the poem has invited discussion of times where they have stepped outside of conventional practices and tried to resist the 'objectifying gaze within which many professionals are trained to speak' (Kinsella, 2006). These offerings are often made tentatively and hesitantly, as if we do not have permission to speak about these matters, perhaps reflecting fears that we are violating accepted notions of professionalism by our very discussion.

Questioning the "received knowledge" (McNamee & Hosking, 2011) about ethics in professional practice, Kinsella's use of a personal voice provides an opening for students to express their own uncertainties and acknowledgement of the ambiguities of day-to-day practice. To further extend the textual conversation about practice ethics, I have crafted some of the students' phrases and images that have "resonated" and "struck a chord" with me (Shotter, 2010) into the following collaborative poem "Drawing the line". This poem can be seen as a form of 'field poetry' and shared inquiry as we construct knowledge and meaning about practice through everyday conversations.

Poem: Drawing the line

The question is:
How much of ourselves
do we bring to our work?
How open should we be
about our own lives?

What would I do
if I ran into a client
somewhere?
I would have to leave.
I couldn't be myself.

---

[73] Accessed 30 March 2013 from www.uwindsor.ca/criticalsocialwork/discourse-analysis-in-critical-social-work-from-apology-to-question.

I guess we're not supposed to treat clients
like friends

Are we?

Some people say it's not professional
to reveal anything (about ourselves)

But we're human too
this is about our shared humanity

Isn't it?

This is an everyday dilemma.
We're affected by our clients
and we (hopefully)
affect them too.

These conversations have reinforced for me that many practitioners are unprepared to deal with the "ubiquitous moral and ethical dilemmas" of everyday practice (Engel et al, 2008: 206) and that the professional curricula need to more explicitly embrace critical reflection on areas of uncertainty and ambiguity in practice (Man Lam et al., 2007).

In her analysis of ethics in physiotherapy practice, Swisher (2002) points out that there has been a shift towards 'mutuality' in practice, but little in the professional ethics literature to support this. Triezenberg and McGrath (2001: 50) also suggests that it is the day-to-day stories that we tell ourselves and each other, rather than abstract frameworks like codes of conduct, that offer a more meaningful account of what it means to be a healthcare provider.

> The professional role is composed primarily of clinical stories and the lessons we learn from those stories... Teaching students professional behaviors begins with telling them our stories... The stories of the clinical interactions that we collect in our own experiences and the stories that we have heard from others define more completely and contextually what it means to be a [practitioner] than do statements in our Standards of Practice or Guides to Professional Conduct.

Greenfield and Jensen (2010) point out in their discussion of everyday ethics that "ethical decision-making can be a messy business... emotions and feelings that are often associated with conflicting ethical issues can result in anxiety and moral distress... more often than not, the code of ethics provide limited guidance to sort through these issues" (89). Acknowledging the messiness of practice ethics thus suggests a new way of looking at professionalism and encourages us as educators to create spaces for trainees to 'step back from their daily work' and "change the conversation" (Engel et al, 2008: 135).

McNamee also suggests that an ethics of psychotherapy would entail a relationally engaged stance with clients and "within such a stance, the ethic of psychotherapy is one of being relationally responsible" (McNamee, 2009: 60). Discussions of Kinsella's poem reinforces the need for an understanding of practice ethics as a relational and negotiated practice (Anderson, 2001) as what constitutes ethical practice is contextual and embedded in our ongoing relationships with others.

In her article 'Ethics and Uncertainty' (2001), Anderson challenges the idea that notions of professionalism are objective or static, encouraging us instead to see professional ethics as a form of socially constructed knowledge – a 'mutual and local process' that needs to make room for multiple voices and perspectives. "Because ethics are socially constructed through language, they are fluid rather than static" (Anderson, 2001a).

Concerned about the unexamined invisible professional discourses that 'construct the backdrop and principles of everyday practices', Anderson asks an important question – 'whose voice gets left out?'

> I do not assume that the ethics of the dominant discourse are precise and fit the unique situation and circumstance of each therapy... we risk deluding ourselves into thinking of ethics as an objective reality that is absolute and fixed. As I have suggested previously, 'Our ethics should not tell us what to do and then we simply do it. Therapists often think and act as if ethics are objective rules; human life is much more complicated than that and calls for one to be able to live with uncertainty (Anderson, 2001: 4).

Urging us to move away from an approach to ethics which is unable to respond sensitively to the "continuous flow of ethical decisions" in clinical practice (Frank, 2004: 18), Hudson Jones (1999) suggests that narrative can help us shift from focusing on abstract principles to a more situated and contextual approach. In this way, stories are useful in "fleshing out" dilemmas in medical ethics by showing them embedded in a particularised human context complicated by 'powerful emotions and complex interpersonal dynamics.

This echoes the discussion on "process ethics" articulated by Swim, St George and Wulff (2001) which focuses on the centrality of 'relational connectedness' to ethical practices. In contrast to standards of conduct which are, by necessity, broad and abstract, they urge practitioners to "privilege the client's perspective as well as the local and unique nature of each therapeutic relationship" (16). Acknowledging that "this process is by nature unscripted and engenders an uncertainty and ambiguity for the therapist that can be quite distressing" they state "we cannot know the nature of the relationship until we are in it and developing it" (18). Such an approach is guided by collaborative principles which honour mutuality in practice relationships and privilege the relational constructs of uncertainty, honesty, caring, and humility.

Carson (2001: 201) suggests that a narrative approach to ethics is reflective enough to acknowledge that in reality, there is always another way to tell a story. Discussing the use of narrative writing in nursing ethics education; Carson reflects on asking students to write about their own ethical dilemmas and frames these narratives as a form of 'reflexive practice'.

> The first point I want to make about stories, is that as well as being texts, they are also practices. While one is tempted to measure them against reality or to see a story as 'about' something else, they are fundamentally practices. The first story the students write up is really for them. Each story, as a reflexive practice, constructs a reality for itself... the stories allow students to evaluate themselves as practising nurses, to see that their practice is a mix of professional duties and personal choices and interpretations.

Acknowledging the complex discourses surrounding day-to-day practice decisions, social work professor Amy Rossiter (2005) points out that critical reflection needs to situate our practice ethics, as well as our failures and successes in "accounts of the complex determinants of practice so that we can acknowledge practice as historically, materially and discursively produced, rather than simple outcomes of theories, practitioners and agencies". Reflecting on critical ethics and the role of narratives in social work training, she states

> I have found myself on the terrain of a kind of critical ethics that views practice theories as stories about the cultural ideals of practice, and that treats practitioners' experiences as stories that can teach us about the conduct of practice in relation to such ideals. My view of critical reflective practice is that it must promote a "necessary distance" from practice in order to enable practitioners to understand the construction of practice, thus enhancing a kind of ethics – or freedom, in Foucault's terms … which opens perspectives capable of addressing questions about social work, social justice and the place of the practitioner.[74]

Kinsella's poem helped me see that my own practice experiences are closely intertwined with larger discourses concerning ethics and professionalism – as well as closely connected with the stories of other practitioners. While one can read Kinsella's poem as a sort of 'morality tale' about the dangers of crossing professional boundaries ('*I transgress by visiting'),* and a caution against unprofessional behaviour (Kinsella, 2006: 43), I would suggest that it is precisely this sense of marginality that gives the poem its power to evoke strong responses and resonance in different ways with many readers. As Kinsella

---

[74] Accessed 30 March 2013 from www.uwindsor.ca/criticalsocialwork/discourse-analysis-in-critical-social-work-from-apology-to-question.

recognizes, the poem speaks to the frustrations and tensions many health care professionals carry and offers a way to "enact lived realities and bring them into conversation with others" (45).

Echoing social theorist bell hooks' (1990) analysis that marginality is a place of resistance, Kinsella calls our attention to the importance of reflecting on practice through "poetic resistance." Kinsella (2006) argues that reflecting in poetic form can illuminate tensions and foreground previously silenced experiences. In particular, she suggests that poetry can offer resistance to the overvaluing of technical and scientific discourses and call attention to ways of creating knowledge that value relationships and situated knowledge (36). In this sense, poetry can provide a way to "see differently" and serve as an acknowledgement of the often untold "messy stories of practice" (38).

Kinsella (2006) reflects on the writing of "Professionalism" and the meaning of the poem for herself as a practitioner and later professor of occupational therapy. In particular, she acknowledges the "lingering sense of discomfort" she felt as a community-based therapist working with Louise and her family. As an "intimate witness" to Louise's illness and her family's despair, she recalls being "unable to find the words to express the conflict that I experienced as a healthcare practitioner in this situation" suggesting that "many practitioners experience tension of this nature day in an day out in professional settings, and it is time that we take such tensions seriously... "(41).

While "Professionalism" is about a particular client, it serves as a valuable opening for us to reflect critically on the many relational dilemmas in our own practice. I would agree with Frank that like all useful narratives, it has an ability to "pose questions and offer examples that inform lives far from the story's particular time and place" (2004: 7). If it is true that "to move us forward, poetry has to take risks, risks that sometimes seem too large" (David Watts, 2000), I would suggest that Kinsella's poem takes risks to help move us forward in redefining relational ethics in practice.

Kinsella's poem has validated for me that poetry can provide rich descriptions of practice, and its provocative voice can provide an opportunity to gain new perspectives on practice (Hunter, 2002). By inviting us into dialogue with the writer's point of view from the perspective of our own (Bochner & Ellis, 2002), poetry has the potential to resonate with our own stories and engender multiple interpretations. It is these multiple interpretations existing "side by side", that makes it so valuable in training practitioners (Raingruber, 2004). Despite the traditional focus within bioethics on the "extreme over the routine" (Kleinman, 1995: 51), poetry focuses our attention on the everyday and teaches us how to operate better in the ongoing midst of complexity (Shotter, 2010; Bolton, 2005).

I would agree with Marcus O'Donnell's reflections on the notion of "space" in teaching: "space is a verb. It is actively created, not just the static background repository we

commonly imagine."[75] This sentiment encourages us, as practitioners and educators, to thoughtfully consider what kind of 'spaces' we are creating for teaching and learning about practice ethics. I would suggest that we need to consider thoughtfully the role of narrative reading and writing in creating more relationally-responsive spaces.

My discussion of poetry in teaching confirms the approach articulated by Frank (2004) that we should aspire to think *with* a story – rather than the more conventional academic approach of thinking *about* stories. Rather than a fixed reading/analysis of a text which provides "an illusion of closure" this approach acknowledges that narratives are part of our ongoing dialogue as "a story is one aspect of a complex of nested relationships that remain in process. Thinking with stories involves taking one's place in that process, in which all participants will continue to tell stories about each other and about themselves" (209).

In thinking about the role of narratives in ethics, Frank (2010) asserts that stories have the ability to engage listeners/readers as "stories teach people what to look for and what can be ignored; they teach what to value and what to hold in contempt" (48). If stories do 'their best work' in helping navigate messy realities and can "prepare people for situations fraught with difficult or subtle choices" (Frank, 2010: 88), then they are valuable resources for relational practice. As McNamee states "as we engage with each other, we not only create a sense of 'who; we are but also a sense of 'what' is valued" (2006: 31).

Perhaps Jane Polkinghorne's (2001: 34) image of novels as 'gatecrashers into serious places' is a useful way to understand the ambiguous, but important, role of narrative in professional practice and teaching.

> Novels sneak into serious places. Some might say they are interlopers, gatecrashers, have tickets on themselves and should be evicted. Some medical students are surprised when I walk into their lecture and quote from well read dog eared favourite novels instead of at the very least from the works of well regarded social researchers.

[75] Accessed 30 March 2013 from http://marcusodonnell.com.

Further conversations and final reflections

The purpose of poetry is to remind us
How difficult it is to remain just one person,
For our house is open, there are no keys in the doors,
And invisible guests come in and out at will.[76]

What could best contain all the complex aspects of practice – the different angles, points of view – is probably a poem.

Tilda Shalof[77]

---

[76] Translated by Czeslaw Milosz and Lillian Vallee in Hirshfield (1998: 205).

[77] Presentation 29 March 2012 in Toronto.

As I come to the end of my thesis, I am interested in reflecting on, and promoting, a *both/and* position towards inquiry. In the interest of widening the conversation to include different forms of research, and provide rich understandings of practice, I reflect on possibilities for further inquiry that combine narrative texts like the ones discussed here with other types of social science knowledge. The integration of multiple forms of knowledge creates openings for generative conversations between texts – a type of intertextuality that can create space for uncertainty, contradiction, and paradox in professional practice (Philips, 2008).

An example of this type of potentially generative conversation would be the integration of Crepeau's (2000) research on talk between healthcare providers with patient or practitioner narratives on the experience of illness and treatment. Crepeau used content analysis to investigate how healthcare providers talk about patients in case conferences and informal consultations. He found that practitioners tended to blame patients who (they perceived) did not cooperate with treatment plans, and did not meet the (unspoken) expectations of their providers. This kind of research foregrounds how healthcare providers function in day-to-day practice, highlights the unexamined assumptions embedded in everyday clinical talk, and clarifies the impact of these assumptions on patient care .

Research into the unexamined aspects of patient care deepens our understanding of practitioner narratives like "The Poor Historian", which draw attention to the way professional communication can inadvertently pathologize and objectify patients. Patient narratives, i.e., first-hand accounts of illness or medical treatment, also serve as important resources for understanding the potentially negative impact of clinical discourse on patients. By drawing attention to the often neglected role of informal talk in healthcare institutions, Crepeau's research spotlights the importance of research that examines "how the written record is tied into and anchored within other aspects of organizational life such as conversations at the nursing station" (Prior, 2004: 382).

This thesis argues for a larger role for narrative interventions in clinical practice, clinical education, and healthcare research. For example, Houston et al (2011) evaluated the impact of narrative-informed clinical interventions. In a randomized controlled trial, they demonstrated that an educational storytelling intervention helped patients manage chronic illness by reducing hypertension.

While my focus has been on the role of narrative writing in exploring (relational aspects of practice through the lens of liminality, there are other theoretical frameworks that could add to our understanding of the meanings of clinical interactions. For example, McKenzie and Carey (2000) draw on social positioning theory as a framework for making sense of clinical encounters and information-seeking behaviour by patients. They examine ways that social identities based on health status are negotiated in clinical interactions by

understanding the ways that both clinicians and patients "position" themselves through dialogue.

In reflecting on my process of undertaking this dissertation, I return to Tilly Warnock's (2000) statement (quoted at the beginning of this dissertation) about the improvisational and profoundly relational nature of writing. My journey has confirmed that both my professional practice and scholarly writing can be viewed as "rough drafts" – full of revisions, unclear trajectories, and "not knowing where we're going before we begin." The metaphor of research-as-collage captures this sentiment, as this thesis has been crafted out of fragments of theory, personal reflections, conversations and stories, tied together and embedded within a larger narrative.

The crafting of this thesis has been a way of acknowledging the role of stories in my practice as a social worker and clinical educator, as well as honouring the tacit knowledge of practitioners. As Rita Wilder Craig (2007: 431) states in reflecting on the pivotal, but often neglected, role of story in our work:

> Social workers have always used narratives in the service of their clients. Many of us spend half our days listening to stories and the other half repeating them in one form or another... While we excel at this kind of storytelling, we have been held back from using the narrative genre in telling our own story.

Echoing the words of academic and poet Carl Leggo, I have been ruminating and writing about my practice through poetry, narrative and "conversations with the words of others" (2010: 69). Like the theatre rehearsal process described by Zandee and Broekhuijsen (2009), where actors strive to maintain complexity and openness for as long as possible and delay the moment when things become fixed in their final form, the idea of unsettledness became an appropriate metaphor for my inquiry. I tried to avoid closing things off and "driving myself into the corner" (Warnock, 2000: 37), and rather allowed the story to unfold through a continual process of reading, writing, reflecting and talking with others.

The text I have produced is thus characterized more by creativity and contingency than by certainty. In trying to maintain a curious stance about practice, I have "come to know something without claiming to know everything" (Richardson, 1994: 518). I have chosen to privilege uncertainty, incompleteness and multiplicity in the inquiry process (McNamee, 2008) and to emphasize those dialogic moments *where we have done something together which neither of us could do separately* (Cissna and Anderson, 1998).

Turning towards relational and constructionist practices has been a process of leaving certain discourses behind – and embracing others. This echoes Norwegian psychiatrist Tom Anderson's reflection that the decision to become a collaborative practitioner was a "fork in the road" of his personal and professional journey. He chose to leave the language of the

hospital behind, and turn to ordinary language "to hold up a differently highlighted picture of who we are and what we do" (Andersen, 2012). In this sense, throughout my dissertation I have tried to offer a different image "of who we are and what we do" through turning to more poetic and narrative perspectives on practice.

Opening my discussion with the story "How and Why We Speak," I firmly anchor this inquiry in my own practice, and signal my interest in personal narrative as a form of professional knowledge. I also signal my interest in collaborative practice, as the lessons I learned in my relationship with Angela continue to resonate in unexpected ways in my work and writing. Even with the passage of time, I have no tidy ending to offer, as the story of that relationship remains messy – embodying the ambiguity, complexity and contradictions of lived experience. The story can be read as an attempt to come to terms with loss, but it does not fit the dominant discourse of grief which emphasizes 'moving on' and 'letting go'; rather it acknowledges the rich stories and conversations that carry on even after death (Hedkte, 2000).

The process of writing about practice has brought home to me how "painful is the search for meaning" and "how complicated people's struggles to tell the truth often are" (Portelli in Frank, 2010: 91). The following statement echoes my thoughts that narrative writing honours the messiness of living.

> As I wrestle with (and enjoy) the ambiguity, complexity and contradiction in lived experience, sometimes now I feel I know a great deal about living in relationships and writing narratives; other times, I'm sure I know almost nothing, even about the most basic process. Thus, there is no simple, tidy ending to this book; there is merely a practical one that honors the messiness of living. (Marcus in Ellis, 2009: 117)

This dissertation, comprised of stories by healthcare practitioner/writers, reaffirms for me the richness and flexibility of liminality and marginality, as conceptual resources for making sense of day-to-day practice. My approach to inquiry occupies a different kind of liminal space, on the border where social science, healthcare and the humanities intersect.

In reflecting on the usefulness of narratives in understanding the in-between spaces and ambiguous meanings of practice and professional identity, my inquiry suggests that there is little difference between the "fictions" of writers and the "facts" of social scientists as "we find two communities that touch even overlap, in complex and unspecified ways" (Phillips, 1995: 628). In blurring the hard line between "fact" and "fiction", the narratives offered in this dissertation provide glimpses into the "everyday routines and rhythms of social life" (Kleinman, 1995: 54).

If narrative is indeed a neglected form of "data" about everyday practice (Stein, 2007: 139), then this inquiry has reinforced the usefulness of art and narrative as ethnographic 'texts' – telling us something about the everyday meanings of practice often overlooked in scholarly work. While this can result in an "uncomfortable confusion of boundaries," it acknowledges that there is no clear line where social science ends and narrative begins (Phillips, 1995). This resonates with my approach to inquiry, in which the hard border between qualitative inquiry, theoretical analysis and narrative writing has been softened to create openings for 'new' conversations.

By positioning myself in the dissertation explicitly as a practitioner, writer *and* narrative researcher, I have become part of the unfolding narrative in multiple ways. This approach has relied heavily on constructionist and relational sensibilities, narrative inquiry and autoethnography which privileges the author's voice in the text. However, in highlighting the dialogical connections of practice narratives, I have come closer to a type of "relational ethnography" – a form of inquiry that emphasizes reflexive and dialogical aspects of research relationships and highlights the relational dimensions of personal stories (Simon, 2013).

Poetry and narrative are versatile approaches for collaborative inquiry, as well as powerful resources for reflecting critically on practice. While my approach draws upon recognized methods of arts-based inquiry, including the use of field poetry and autoethnographic poetry (Butler-Kisber, 2012), I have also used existing poems and stories as 'objects' of inquiry – vehicles to think about healthcare practices and their relational ethical implications. In addition, I have used my own and others' poems and stories to extend dialogue and keep the conversation going..

In incorporating stories (my own and others), I have focused on personal narrative as a "legitimate form of scholarship which is not bounded by false divisions between one's work and one's life" (Goodman, 2011). Like cultural anthropologist Barbara Myerhoff, who challenged the line between scholarship, personal narrative and the arts, I have not resolved the tension between "academic scholarship and personal quest" (1978: 11-12). Ultimately this thesis is a bit of both.

In dissolving the boundaries of scholarly research, personal narrative and creative writing, this thesis has confirmed for me the "generative power" (Jackson, 2012) of poetry, and shifted my identity towards that of a 'poet/practitioner' (Furman et al, 2011). This has reinforced the idea that social scientists can draw from the literary crafts to create richly-drawn accounts of practice. Thus practices like writing fieldwork poems and "noticing through note taking" (a favourite strategy of writers who always manage to have a notebook nearby) can be catalysts for making "unexpected connections" and "re-imagining the familiar" in social science inquiry (Cahnmann, 2003: 32).

While I worked at the kitchen table one evening, my son, who was 16-years-old at the time, asked, "what does your thesis have to do with anything real?" His question prompted me to reflect on the artificial distinction between "theory" and "practice." It strikes me that the tensions between the theoretical and the practical in social science discourses could be dissolved by the idea of "practical theory" that encourages a simultaneous commitment to theoretical discussion and practical application.[78]

In blurring this distinction, I also look to literary critic Anatole Broyard who reflected on his experience with illness by writing, "in emergencies we invent narratives" (in Mattingly, 1998: 1). This sentiment is expressed in a slightly different, but equally evocative way, by poet Shirley Serviss' (2007): "poetry is an insurance policy / in the best of times / and the worst of times." This invites us to think about the role of narrative in navigating the challenges of day-to-day working/living, and echoes Kenneth Burke's powerful idea of narratives as "equipment for living". In other words, narratives are practical.

This thesis embodies three levels of reflection. First, the poems and stories give voice to writers reflecting on particular moments of their practice. Second, the texts offer an opportunity for the reader of this thesis to reflect on the experience of other writers. And finally, the sea of practitioner narratives I have been immersed in highlights the potential role of narrative to change healthcare practice and education (Charon, 2012). It is this possibility of having a broader view, or seeing through a "wider lens", that Frank (2010) emphasizes in his discussion of the value of narrative inquiry.

I see my inquiry as part of a larger conversation about the role of narrative in changing healthcare discourses and practices so that students and practitioners can work towards a better future. This involves constructing 'preferred' identities as professionals, where we can "be at [our] best" (Engel, 2008: 135). In reflecting on the importance of stories in understanding what it means to be a healthcare professional, Engel et al (2008) suggest that the collective stories of practitioners are a powerful resource for changing practice as writing offers alternative voices and invites multiple meanings. I am particularly interested in the role of narrative writing in giving space to local realities, and in "opening up possibilities for re-storying practice" (McNamee and Hosking, 2012: 52).

In this sense, narratives are profoundly useful as they are practical resources for the development of alternative narratives. The writers here challenge the privileging of biomedical discourses and the dichotomy between personal and professional identities to create space for other kinds of stories. These stories resist the flatness of dominant narratives, and create space for the ambiguity and complexity of lived experience.

---

[78] Sheila McNamee, Social Constructionist Workshop, Taos Institute, June 2011.

In acknowledging that discourses (or dominant assumptions and taken for granted practices) are always subject to challenge and change (Monk & Winslade, 2013), counter stories are viable alternatives because they amplify the tensions within official discourses.. Practitioner narratives can thus be viewed as 'storying' those moments in healthcare practice that otherwise remain underneath the dominant narrative; those stories that would remain "masked" or "subjugated" (Monk & Winslade, 2013). As Nelson (2001) writes, many of these stories "start small, like a seed in the crack of a sidewalk, but they are capable of displacing surprising chunks of concrete as they grow" (169).

Mindful of Kenneth Gergen's caution not to reify constructionist paradigms as a "reflection of true reality" (Priya, 2012), I am drawn to the idea that narrative creates new discursive realities. In challenging unexamined discourses of practice, narrative writing resides in the margins to provide counter narratives of practice – stories that "lie in tension with the ones that we are socialized to expect" (Andrews et al, 2004: 109) and that validate practices that go against the grain of conventional practices (Brookfield, 2008).

In considering the question, "How does the story change people's sense of what is possible, what is permitted?" (Frank, 2010: 75), I am drawn to the idea that stories "transport us to other times and places where we can experience things otherwise" (Engel, 105). In pondering the question, "How do we wish to build our future together?" (Gergen and Gergen, 2008), narratives are resources for imagining "how things could and should be" (Warnock, 2000: 36). If practitioners negotiate moral and existential dilemmas in day-to-day practice (Mattingly, 1998: 20), then writing is a way to engage the moral imagination.

Borrowing the idea that "discourses can change and evolve when conversations between people affect culturally available narratives" (Freedman and Combs, 1998: 43), practice stories widen the pool of available narratives. In short, they act as "fluid resources for action" (McNamee, 2012). This has brought me to reflect on how we choose to act in the day-to-day realities – and messiness – of practice. In trying to answer Frank's questions (2004), "Who are [we] choosing to be" and "Who will [we] be tomorrow?", we can look to the possibilities of narrative writing to give voice those relational moments of professional practice that might otherwise go unnoticed.

In contrast to scholarly conventions that one must claim the last word, I prefer to see my inquiry as a work in progress – part of a process of "perpetual generation – where one story calls forth, and echoes, another" (Frank, 2005: 966). If we take seriously Burke's (1974) metaphor of an "unending conversation", then this thesis is part of an ongoing and unfolding narrative. Dialogical inquiry challenges attempts to finalize meaning and cautions against the author/researcher having the final word. As "each ending is a new beginning" (McNamee & Hosking, 2012: 151), I invite you, the reader, to continue the conversation.

Bibliography

Abrahams, R. 2005. *Everyday Life: a Poetics of Vernacular Practices*. University of Pennsylvania Press.

Adame, A. & Knudson, R. 2007. "Beyond the Counter-narrative: Exploring Alternative Narratives of Recovery from the Psychiatric Survivor Movement." In *Narrative Inquiry*, 17(2): 157-178.

Ahlzen, R. & Stolt, C.M. 2001. "Poetry, Interpretation and Unpredictability: a Reply to Neil Pickering." *Journal of Medical Ethics: Medical Humanities*, 27: 47-49.

Alcauskas, M. & Charon, R. 2008. "Right Brain: Reading, Writing and Reflecting – Making a Case for Narrative Medicine in Neurology." *Neurology* 70 (11): 891-894.

Andersen, T. 2012. "Words – Universes Traveling By." In Malinen, T. & Scot, C. (Eds.), *Masters of Narrative and Collaborative Therapies: the Voices of Andersen, Anderson and White*. Routledge: Taylor & Francis Group.

Andersen, T. '*Ethics, Ontology and Peace*'. *The New Therapist Magazine.* Accessed 5 April 2013 from www.newtherapist.com/andersen5.html.

Anderson, H. 2012. "Possibilities of the Collaborative Approach." In *Masters of Narrative and Collaborative Therapies*. New York: Routledge.

Anderson, H. 2007a. "A Postmodern Umbrella: Language and Knowledge as Relational and Generative, and Inherently Transforming." In Anderson, H. & Gehart, R. (Eds.), *Collaborative Therapy: Relationships and Conversations that Make a Difference*. New York: Routledge.

Anderson, H. 2007b. "The Heart and Spirit of Collaborative Therapy: the Philosophical Stance – 'A Way of Being' in Relationship and Conversation." In Anderson, H. & Gehart, R. (Eds.), *Collaborative Therapy: Relationships and Conversations that Make a Difference*. New York: Routledge.

Anderson, H. 2003. "Post Modern Social Construction Therapies." In Sexton, T. & Weeks, G. (Eds.), *Handbook of Family Therapy: the Science and Practice of Working with Families and Couples*, Routledge.

Anderson, H. 2001a. "Ethics and Uncertainty: Brief Unfinished Thoughts." Journal of Systemic Therapies, 20(4): 3-6.

Anderson, H. 2001b. "Becoming a Postmodern Collaborative Therapist: A Clinical and Theoretical Journey. Part II." *Journal of the Texas Association for Marriage and Family Therapy*. 6(1): 4-22.

Anderson, H. 1997. *Conversation, Language, and Possibilities: A Postmodern Approach to Therapy*. New York: Basic Books.

Andrews, H. & Roberts, L. (Eds.). 2012. *Liminal Landscapes: Travel, Experience and Space In-between*. New York: Routledge.

Andrews, M. et al. 2007. "Narrative Research." In Gobo, C., Seale, C., Silverman, D. & Gubrium, J. (Eds.), *Qualitative Research Practice*, Sage Publications.

Andrews, M., Day-Schlater, S., Squire, C., & Tamboukou, M. 2004. "Narrative Research." In Seale, C. et al (Eds.), *Qualitative Research Practice*, Sage Publications.

Balen, R., Rhodes C. & Ward, L. 2010. "The Power of Stories: Using Narrative for Interdisciplinary Learning in Health and Social Care." *Social Work Education*, 29(4).

Bamberg, M. & Andrews, M. (Eds.). 2004. *Considering Counter Narratives: Narrating, Resisting, Making Sense*. John Benjamins Publishing.

Baumann, S. 1999. "Art as a Path of Inquiry." *Nursing Science Quarterly*, 12(2): 106-110.

Beck, E.T. 2010. "Embracing Poetry in Unexpected Places." *Journal of Poetry Therapy* 23(4): 201-214.

Beech, N. 2011. "Liminality and the Practices of Identity Reconstruction." *Human Relations*, 64.

Behan, C. 2003. "Rescued Speech Poems: Co-authoring Poetry in Narrative Therapy."Accessed 12 April 2013 from www.narrativeapproaches.com/narrative%20papers%20folder/behan.htm.

Binder, M. 2011. "Remembering Why: the Role of Story in Educational Research." *Education*, Journal of the Faculty of Education, University of Regina, 17(2).

Birnbaum, R. 2004. Interview with Rafael Campo. Accessed 30 March 2013 from http://www.themorningnews.org/article/birnbaum-v.-rafael-camo.

Bleakley, A. 2000. "Writing with Invisible Ink: Narrative, Confessionalism and Reflective Practice." *Reflective Practice*, 1(1). 11-24.

Bloom, R. 2000. "Personal Effects." In Follett, B. (Ed.), *Personal Effects*. Pedlar Press.

Blows, E., Bird, L., Seymour, J., & Cox, K. 2012. "Liminality as a Framework for Understanding the Experience of Cancer Survivorship: A Literature Review." *Journal of Advanced Nursing*, 68(10): 2155-2164, October. Blackwell Publishing Ltd.

Blumenfeld, E. 2011. "Poetry of Witness, Survivor Silence, and the Healing Use of the Poetic." *Journal of Poetry Therapy*, 24(2): 71-78.

Bolton, G. 2005. "Opening the Word Hoard: Stories for Change." *Journal of Medical Ethics*, 32: 43-47.

Bolton, G. 2006. "Narrative Writing: Reflective Enquiry into Professional Practice." *Educational Action Research*, 14(2): 203-218.

Braude, H. 2012. "Normativity Unbound: Liminality in Palliative Care Ethics." *Theoretical Medicine and Bioethics*, 33(7): 107-122.

Brody, H. 2002. "Narrative Ethics and Institutional Impact." In Charon, R. & Montello, M. (Eds.), *Stories Matter: the Role of Narrative in Medical Ethics*. New York: Routledge.

Brookfield, S. 2008. "Clinical Reasoning and Clinical Decision Making – Nature and Context." In Higgs, J., et al. (Eds.), *Clinical Reasoning in the Health Professions.* Toronto: Elsevier Health Sciences.

Brown, S., Fox, S. & Jaquet, S. 2007. "On the Beach: Liminal Space in Historical and Cultural Contexts." *Limina: A Journal of Historical and Cultural Spaces*. Accessed 30 March 2013 from http://www.limina.arts.uwa.edu.au/__data/page/115716/Introfinal4.pdf.

Brown, T. 2011. "Caring for the Chart or the Patient?" Accessed 30 March 2013 from http://well.blogs.nytimes.com/2011/02/02/caring-for-the-chart-or-the-patient.

Buber, M. 2002. *Meetings: Autobiographical Fragments*. London: Routledge.

Burke, K. 1966. *Language as Symbolic Action. Essays on Life, Literature and Method*. Berkeley: University of California Press.

Burke, K. 1974. *The Philosophy of Literary Form*. Berkeley: University of California Press.

Burman, E. 2006. "Analytic Third or Law? Reflection vs. Regulation in Psychotherapy Case Notes." *Feminism & Psychology*, 16(4): 445-450.

Burr, V. 2003. *Social Constructionism* (2nd Edition). New York: Routledge.

Butler-Kisber, L. 2012. "Poetic Inquiry." In *The Art of Poetic Inquiry.* Thomas, S., Cole, A. and Stewart, S. (Eds.) Halifax: Backalong Books.

Butler-Kisber, L. & Poldma, T. 2010. "The power of visual approaches in qualitative inquiry: The use of collage making and concept mapping in experiential research." *Journal of Research Practice*, 6(2), Article M18. Accessed 30 March 2013 from http://jrp.icaap.org/index.php/jrp/article/view/197/196.

Butler-Kisber, L. 2010. Qualitative Inquiry: Thematic, Narrative and Arts-Informed Perspectives. London: Sage Publications.

Cahnmann, M. 2003. "The Craft, Practice, and Possibility of Poetry in Educational Research." *Educational Researcher*, 32(3): 29-36.

Campo, R. 1997. *The Desire to Heal: A Doctor's Education in Empathy, Identity and Poetry*. New York: W.W. Norton & Company.

Campo, R. 2003. *The Healing Art: A Doctor's Black Bag of Poetry*. New York: W.W. Norton & Company.

Campo, R. 2005. "That Wounds Might Speak." *The Lancet*, 365(9454): 113-114, 8 January.

Campo, R. 2011. "Illness as Muse." *Bellevue Literary Review*. Accessed 30 March 2013 from http://blr.med.nyu.edu/content/current/illnessasmuse.

Cantor, A. 1995. *Crafted Bodies: Interpretations of Corporeal Knowledge in Light of the Technological Imagination in Antiquity, the Renaissance and the Present*. Unpublished Masters Thesis, University of Toronto.

Carson, A. 2001. "That's Another Story: Narrative Methods and Ethical Practice." *Journal of Medical Ethics*, 27: 198-202.

Carson, R. 2002. "The Hyphenated Space: Liminality in the Doctor Patient Relationship." In Charon, R. & Montello, M. (Eds.) *Stories Matter: the Role of Narrative in Medical Ethics*.

Chamberlain, S. 2006. "Reflecting on the Third Voice from a Narrative Perspective." *Feminism and Psychology*, 16(4): 469-474.

Chambon, A. 2005. "Social Work Practices of Art." *Critical Social Work: an Interdisciplinary Journal*, 5(1). April.

Chan, E.A. 2008. "The Spiral: the Meaning of Caring in Practice." In Schwind, J. & Lindsay, G.M. (Eds.) *From Experience to Relationships: Reconstructing Ourselves in Education and Healthcare*. North Carolina: Information Age Publishing.

Charles, C. 2001. "The Meaning(s) of Uncertainty in Treatment Decision-making." In Higgs, J. & Titchen, A. (Eds.), *Professional Practice in Health, Education and the Creative Arts.* Cornwall: Blackwell Science.

Charmaz, K. 2002. "Stories and Silences: Disclosures and Self in Chronic Illness." *Qualitative Inquiry*, 8(3): 302-328.

Charon, R. & Hermann, N. 2012. "A Sense of Story, or Why Teach Reflective Writing." *Academic Medicine,* 87(1): 5-7.

Charon, R. 2012. "Commentary: Our Heads Touch: Telling and Listening to Stories of Self." *Academic Medicine*, 87(9): 1154-1156.

Charon, R. 2007. "What to do with stories: the sciences of narrative medicine." *Canadian Family Physician*, 53(8): 1265-1267.

Charon, R. 2006. "The Self Telling Body." *Narrative Inquiry*, 16(1): 191-200.

Charon, R. 2006. *Narrative Medicine: Honoring the Stories of Illness.* New York: Oxford University Press.

Charon, R. & Montello, M. (Eds.). 2002. *Stories Matter: the Role of Narrative in Medical Ethics*. New York: Routledge.

Charon, R. 2001. "Narrative Medicine: A Model for Empathy, Reflection, Profession and Trust." *Journal of American Medical Association*, 286(15): 1897-1902.

Cissna, K. & Anderson, R. 1998. "Theorizing about Dialogic Moments: the Buber-Rogers Position and Postmodern Themes." *Communication Theory*, 8(1): 63-104.

Clandinin, D.J. & Connelly, F.M. 2000. *Narrative Inquiry: Experience and Story in Qualitative Research*. San Francisco: Jossey-Bass Publishers.

Clifford, J. 1986. "Introduction: Partial Truths." In Clifford, J. & Marcus, G. (Eds.). *Writing Culture: the Poetics and Politics of Ethnography*, University of California Press.

Cloak, P. & Jones, O. 2001. "Dwelling, Place and Landscape: an orchard in Somerset." *Environment and Planning*, 33: 649-666.

Coles, R. and Tetsa, R, Eds. (2002). *A Life in Medicine: A Literary Anthology*. New York: The New Press.

Coles, R. 1989. *The Call of Stories: Teaching and the Moral Imagination*. Boston: Houghton Mifflin.

Connelly, J. 2002. "In the Absence of Narrative." In Charon, R. & Montella, Eds., *Stories Matter: the Role of Narrative in Medical Ethics*.

Connelly, M. & Clandinin, J. (Eds). 1999. *Shaping a Professional Identity: Stories of Educational Practice*. New York: Althouse Press.

Connelly, M. & Clandinin, J. 1994. "Telling Teaching Stories." *Teacher Education Quarterly*, 21(1): 145-58.

Davis, C. "Of Poetry and Medicine: Rafael Campo in Conversation." Accessed 30 March 2013 from http://www.poets.org/viewmedia.php/prmMID/19160.

Crepeau, E. 2000. "Reconstructing Gloria: A Narrative Analysis of Team Meetings." *Qualitative Health Research*, 10(6): 766-787.

Crocket, K. 2002. "From Narrative Practice in Counselling to Narrative Practice in Research: a Professional Identity Story." *The International Journal of Narrative Therapy and Community Work*. No 4, Adelaide: Dulwich Centre Publications.

Cunliffe, A.L. 2002a. "Social Poetics as Management Inquiry: A Dialogical Approach." *Journal of Management Inquiry*, 11(2): 128-146.

Cunliffe, A.L. 2002b. "Everyday conversations: a social poetics of managing." *Concepts and Transformation*, 6(3): 295-315.

DasGupta, S. & Charon, R. 2004. "Personal Illness Narratives: using reflective writing to teach empathy." *Academic Medicine*, 79(4): 351-6.

DasGupta, S. & Hurst, M. (Eds.). 2007. *Stories of Illness and Healing: Women Write Their Bodies*, Kent State University Press.

DasGupta, S. 2008. "Narrative Humility." *The Lancet*, 371: 980-981.

DasGupta, S. 2011. "Listening as Freedom: Narrative, Health and Social Justice." In Buckley, L., DasGupta, S. & Zarconi, J. (Eds.). *Pay attention!: Caregiving is all about Story*. (Conference Proceedings). Institute for Professional Inquiry.

Davies, C. 1999. *Reflexive Ethnography: A Guide to Researching Selves and Others*. New York: Routledge.

Davis, C. & Schaefer, J. 1995. *Between the Heartbeats: Poetry and Prose by Nurses*. University of Iowa Press.

De Certeau, M. 1984. *The Practice of Everyday Life*. University of California Press.

Denborough, D. 2011. "Resonance, Rich Description and Social-Historical Healing." *The International Journal of Narrative Therapy and Community Work*, No 3. Adelaide: Dulwich Centre Publications.

Denshire, S. 2009. *Writing the Ordinary: Auto-ethnographic Tales of an Occupational Therapist*. Unpublished Ph.D. dissertation. Charles Sturt University, Australia.

Denshire, S. 2010. "The Art of "Writing in" the Hospital Under-Life: Auto-Ethnographic Reflections on Subjugated Knowledges in Everyday Practice." *Reflective Practice* 11(4): 529-544.

Denzin, N. & Lincoln, Y.S. (Eds.). 2011. *The SAGE Handbook of Qualitative Research*. California: Sage Publications.

Denzin, N. 1997. "Performance Texts." In Tierney, W. & Lincoln, Y. (Eds.). *Representation and the Text: Re-Framing the Narrative Voice*, State University of New York Press.

Downie, G. 1999. *Wishbone Dance: New and Selected Medical Poems*. Toronto: Wolsak and Wynn Publishers.

Duhamel, D. & Seaton, M. 2006. "Poetry and Collaboration." Accessed 30 March 2013 from http://www.poets.org/viewmedia.php/prmMID/19335.

Elizabeth, V. 2008. "Another String to our Bow: Participant Writing as Research Method." *Forum: Qualitative Social Research*, 9(1) January.

Ellis, C. & Bochner, A. 2000. "Autoethnography, Personal Narrative, Reflexivity." In N.K. Denzin & Lincoln, Y.S. (Eds.). *Handbook of Qualitative Research* (2nd Edition). CA: Sage Publications.

Ellis, C. 1997. "Evocative Autoethnography: Writing Emotionally about Our Lives." In Tierney, W. & Lincoln, Y. (Eds.). *Representation and the Text: Re-Framing the Narrative Voice*. State University of New York Press.

Ellis, C. 2008. *Revision: Autoethnographic Reflections on Life and Work*. California: Left Coast Press.

Ellis, C., Adams, T., & Bochner, A. 2011. *Autoethnography: an Overview*. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 12(1). Accessed 30 March 2013 from http://www.qualitative-research.net/index.php/fqs/article/view/1589/3095.

Elwyn, G. & Gwyn, R. 1988. "Stories we Hear and Stories we Tell… Analyzing Talk in Clinical Practice." In Greenhalgh, T. & Hurwitz, B. (Eds.). *Narrative-Based Medicine: Dialogue and Discourse in Clinical Practice*. London: BMJ Books.

Engel, J., Zarconi, J., Pethtel, L., & Missimi, S. 2008. *Narrative in Health Care: Healing Patients, Practitioners, Profession and Community*. New York: Radcliffe Publishing.

Finlay, L. 2002. Negotiating the Swamp: the Opportunity and Challenge of Reflexivity in Research Practice. Qualitative Research, 2(2): 209-230.

Fisher, P. & Goodley, D. 2007. "The Linear Medical Model of Disability: Mothers of Disabled Babies Resist with Counter-Narratives." *Sociology of Health and Illness*, 29(2): 66-81.

Flemons, D. & Green, S. 2002. "Stories that Conform/Stories that Transform: A Conversation in Four Parts." In Bochner, A. & Ellis, C. (Eds.). *Ethnographically Speaking: Autoethnography, Literature and Aesthetics*. California: AltaMira Press.

Foote, J.L., Houston, D.J. & North, N.H. 2002. "Betwixt and Between: Ritual and the Management of an Ultrasound Waiting List." *Health Care Analysis*, 10: 357-377.

Frank, A. 2004. "Asking the Right Question about Pain: Narrative and Phronesis." *Literature and Medicine*, 23(2): 209-225.

Frank, A. 2004. *The Renewal of Generosity: Illness, Medicine and How to Live*. Chicago: the University of Chicago Press.

Frank, A. 2005. "What is Dialogical Research and Why Should We Do It?" *Qualitative Health Research*, 15, 2005: 964-974.

Frank, A. 2012. "Reflective healthcare practice: Claims, phronesis and dialogue." In Kinsella, E.A. & Pitman, A. (Eds.). 2012. *Phronesis as Professional Knowledge: Practical Wisdom in the Professions*. The Netherlands: Sense Publishers.

Freedman, J. & Combs, G. 1998. *Narrative Therapy: the Social Construction of Preferred Realities*. New York: W.W. Norton & Company.

Furman, R. 2004. "Using Poetry and Narrative as Qualitative Data: Exploring a Father's Cancer Through Poetry." *Families, Systems & Health*, 22(2): 162-170.

Furman, R. 2005. "Using Poetry and Written Exercises to teach Empathy." *Journal of Poetry Therapy*, 18(2): 103-110.

Furman, R., Langer, C. & Anderson, D. 2006. "The Poet/practitioner: a Paradigm for the Profession." *Journal of Sociology and Social Welfare*, 33(3).

Garro, L. & Mattingly, C. 2000. "Narrative as Construct and Construction." In Mattingly, C. & Garro, U. (Eds.). *Narrative and the Cultural Construction of Illness and Healing*, University of California Press.

Gergen, K. & Gergen, M. 1997. "Narratives of the Self." In Hinchman, L.P. & Hinchman, S.K. (Eds.). *Memory, Identity, Community: the Idea of Narrative in the Human Sciences*. State University of New York Press.

Gergen, K. & Gergen, M. 2008. *Social Construction: Entering the Dialogue* (Second Printing). Taos Institute Publications.

Gergen, K. 2009. *An Invitation to Social Construction* (2nd edition). Sage Publications.

Gergen, K. 2009. *Relational Being: Beyond Self and Community*. New York: Oxford University Press.

Gergen, K., McNamee, S., & Barrett, F. 2001. "Toward Transformative Dialogue." *International Journal of Public Administration*, 24(7&8): 679-707.

Gergen, M. & Gergen, K. 2002. "Ethnographic Representation as Relationship." In Bochner, A. & Ellis, E. (Eds.), *Ethnographically Speaking: Autoethnography, Literature and Aesthetics*.

Gingras, J. & Atkins, J. 2010. "Mapping Resiliency: building bridges toward the future – an experiential arts-based narrative inquiry with dietetic professionals." In McLean, C. (Ed.). *Creative Arts in Interdisciplinary Practice: Inquiries for Hope & Change*, Alberta: Detselig Enterprises.

Gingras, J. 2007. "Giving voice to my own astonishment." *Canadian Creative Arts in Health, Training and Education Journal*, 5(12), March.

Giroux, H., Lankshear, C., McLaren, C., & Peters, M. 1996. *Counternarratives: Cultural Studies and Critical Pedagogies in Postmodern Spaces*, New York: Routledge.

Gold, K. 2007. "How and Why We Speak: Reflecting on Loss and Connection." *Reflections: narratives of professional helping*, 13(2): 39-42.

Gold, K. 2012. "Poetic Pedagogy: A Reflection on Narrative in Social Work Practice and Education." *Social Work Education: the International Journal*, 31(6): 756-763.

Gold, K. 2013. "A Space for Stories: Revisiting Relational Poetry as Collaborative Inquiry on Everyday Practice." *Qualitative Social Work (online).* Accessed 30 March 2013 from http://qsw.sagepub.com/content/early/recent.

Good, B. & Delvecchio-Good, M.J. 2000. "Fiction and Historicity in Doctors Stories: Social and Narrative Dimensions of Learning Medicine." In *Narrative and the Cultural Construction of Illness and Healing*, Mattingly C. & Garro L. (Eds.). California: University of California Press.

Goodman, B. 2011. "The Sociological Imagination, Provocative Pedagogy and Scholarship: Re-Valuing Thinking and Writing in Nurse Education." *Nurse Education Today*, 31(5): 427-28.

Grace, A. 2001. "Poetry is Narrative Inquiry." In Neilsen, L., Cole, A., Knowles, J.G. (Eds.), *The Art of Writing Inquiry.* Halifax: Backalong Books.

Greenfield, B. & Jensen, G. 2010. "Beyond A Code of Ethics: Phenomenological Ethics for Everyday Practice." *Physiotherapy Research International*, 15(2): 88-95.

Greenhalgh, T. & Hurwitz, B. (Eds.). 1998. *Narrative-Based Medicine: Dialogue and Discourse in Clinical Practice.* London: BMJ Books.

Greenhalgh, T. & Hurwitz, B. 1999. "Why Study Narrative?" *British Medical Journal*, January: 48-50.

Greenhalgh, T. 2001. "Storytelling Should be Targeted Where it is Known to Have Greatest Added Value." *Medical Education*, 35: 818-819.

Guenaes, C. & Rasera, E. 2006. "Therapy as Social Construction: an Interview with Sheila McNamee." *International Journal of Psychology*, 40(1).

Gustavson, L. & Cytrynbaum, J. 2003. "Illuminating Spaces: Relational Spaces, Complicity and Multisited Ethnography." *Field Methods*, 15(3): 252-270.

Hall, K. & Nel, D. 2007. "Attention to Language: an Interview with Catherine Belsey." *Limina: A Journal of Historical and Cultural Studies*, 13: 1-5.

Hammersley, M. 2004. "Teaching Qualitative Method: Craft, Profession or Bricolage?" In Seale, C., et al (Eds.). *Qualitative Research Practice,* London: Sage Publications.

Hammerwold, S. 2005. "Writing Bridges: Memoirs Potential for Community Building." *ThirdSpace: a journal of feminist theory and culture*, 5(1), July. Accessed 30 March 2013 from http://www.thirdspace.ca/journal/article/view/hammerwold.

Hare-Mustin, R. 1994. "Discourses in the Mirrored Room: A Postmodern Analysis of Therapy." *Family Process*, 33: 19-35.

Harris, A. 2008. "The Artist as Surgical Ethnographer: Participant Observers Outside the Social Sciences." In *Health: an Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 12(4): 501-514.

Hartman, A. 2000. "In Search of Subjugated Knowledge." *Journal of Feminist Family Therapy*, 11(4): 19-23.

Hasselkus, B.R. 2006. "The World of Everyday Occupation: Real People, Real Lives." *The American Journal of Occupational Therapy*, 60(6): 627-639.

Heath, I. 1998. "Following the Story." In Greenhalgh, T. & Hurwitz, B. (Eds.), *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice.*

Hedkte, L. 2000. "Dancing with Death." Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice, No 2.

Higgs, J. & Titchen, A. 2001. Professional Practice in Health, Education and the Creative Arts.

Higgs, J. 2012. "Realising Practical Wisdom from the Pursuit of Wise Practice." In Kinsella, E.A. & Pitman, A. (Eds.), *Phronesis as Professional Knowledge: Practical Wisdom in the Professions.* The Netherlands: Sense Publishers.

Hirshfield, J. 1998. "Writing and the Threshold Life." In *Nine Gates: Entering the Mind of Poetry*. New York: Harper Collins.

Hogarth, S. & Marks, L. 1998. "The Golden Narrative in British Medicine." In *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice.*

Holman Jones, S. 2004. "Building Connections in Qualitative Research: Carolyn Ellis and Art Bochner in Conversation with Stacy Holman Jones." *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 5(3), Art. 28.

Holmes, V. & Gregory, D. 1998. "Writing Poetry: a Way of Knowing Nursing." *Journal of Advanced Nursing* 28(6): 1191-1194.

hooks, b. 1990. "Choosing the Margin as a Space of Radical Openness." In *Yearning: Race, Gender and Cultural Politics.* Toronto: Between the Lines Press.

Horsfall, D., Byrne-Armstrong, H. & Rothwell, R. 2001. "Embodying Knowledges: Challenging the Theory/Practice Divide." In Higgs, J. & Titchen, A. (Eds.), *Professional Practice in Health, Education and the Creative Arts*.

Houston, T. et al. 2011. "Culturally Appropriate Storytelling to Improve Blood Pressure: A Randomized Trial." *Annals of Internal Medicine*, 154(2): 77-84.

Hudson Jones, A. "The Color of the Wallpaper: training for narrative ethics." In Charon, R. & Montello, M. (Eds.) *Stories Matter: the role of narrative in medical ethics.*

Hudson Jones, A. 1999. "Narrative in Medical Ethics." *British Medical Journal*, January 23: 318: 253–256.

Hughes, G. 2009. "Talking to Oneself: Using Autobiographical Internal Dialogue is Critique Everyday and Professional Practice." *Reflective Practice,* 10(4): 451-463.

Hunter, K. 1993. *Doctors' Stories: the Narrative Structure of Medical Knowledge*. Princeton University Press.

Hunter, L. 2002. "Poetry as an Aesthetic Expression for Nursing: a Review." *Journal of Advanced Nursing,* 40(2): 141-8.

Jackson, M. 2012. *Between One and One Another*. Berkeley: University of California Press.

Katz, A., Conant Jr., L., Inui, T.S., Baron, D., Bor, D. 2000. "A council of elders: creating a multi-voiced dialogue in a community of care."*Social Science and Medicine*, 50: 851-860.

Katz, A. M. and Shotter, J. 1996. "Hearing the Patient's 'Voice': Toward a Social Poetics in Diagnostic Interviews. *Social Science Medicine*, 43(6): 919-931.

Kent, R.D. 2008. "An Inquiry into Mindful Caring: A Narrative Account of my Experience in Day Surgery." In Schwind, J. & Lindsay, G.M. (Eds.). *From Experience To Relationships: Reconstructing Ourselves in Education and Healthcare.*

Kincheloe, J. 2005. "On the Next Level: Continuing the Conceptualization of the Bricolage." *Qualitative Inquiry,* 11(3): 323-350.

Kinsella, E.A. & Pitman, A. (Eds.). 2012. *Phronesis as Professional Knowledge: Practical Wisdom in the Professions.* The Netherlands: Sense Publishers.

Kinsella, E.A. 2005. "Constructions of self: ethical overtones in surprising locations." *Journal of Medical Ethics,* 31: 67-71.

Kinsella, E.A. 2006. "Poetic Resistance: Juxtaposing Personal and Professional Discursive Constructions in a Practice Context." *Journal of the Canadian Association for Curriculum Studies,* 4(1), Fall 2006.

Kinsella, E.A. 2007. "Educating Socially Responsive Practitioners: What Can The Literary Arts Offer Health Professional Education?" In D. Clover, & J. Stalker (Eds.), *The Arts and Social Justice: Re-Crafting Adult Education and Community Cultural Leadership*. UK: NIACE.

Kinsella, E.A. 2007. "Technical Rationality in Schon's Reflective Practice: Dichotomous or Non-Dualistic Epistemological Position." *Nursing Philosophy,* No 8: 102-113.

Kleinman, A. 1995. *Writing at the Margin: Discourse between Anthropology and Medicine*. University of California Press.

La Shure, C. 2005. "About: What is Liminality?" Accessed 5 April 2013 from http://www.liminality.org/about/whatisliminality/.

Lamott, A. 1994. *Bird by Bird: Some Instructions on Writing and Life.* New York: Doubleday.

Lather, P. 2010. *Engaging Science Policy: from the Side of the Messy*. Lang, Peter Publishing.

Leavy, P. 2009. *Method Meets Art: Arts-Based Research Practice.* New York: Guilford Press.

Leggo, C. 2010. "Lifewriting: A Poet's Cautionary Tale," *Poetry and Education: Possibilities and Practices*, 4(1). Accessed 30 March 2013 from http://cer.upei.ca/files/cer/LL-no7-v-final-LR.pdf.

Lewis, B. 2011. *Narrative Psychiatry: How Stories Can Shape Clinical Practice*. John Hopkins University Press.

Lincoln, Y. 1997. "Self, Subject, Audience, Text: Living at the Edge, Writing in the Margins." In Tierney, W. & Lincoln, Y. (Eds.) *Representation and the Text: Reframing the Narrative Voice.* State University of New York Press.

Lindsay, G.M. 2008. "Who You Are as a Person is Who You Are as a Nurse: Construction of Identity and Knowledge." In Schwind, L. & Lindsay, G.M. (Eds.). *From Experience is Relationships: Reconstructing Ourselves in Education and Healthcare.*

Lockford, L. 2002. "Breaking Habits and Cultivating Home." In Bochner, A. & Ellis, C. (Eds.), *Ethnographically Speaking: Autoethnography, Literature and Aesthetics*.

MacRae, C. 2010. "To be Human with Other Humans: a Caregiver's Narrative." In McLean, C. (Ed.), *Creative Arts in Interdisciplinary Practice: Inquiries for Hope & Change*, Alberta, Detselig Enterprises Ltd.

Maggisano, C. 2008. "Crafting an Identity: Toward an Understanding of the Importance of Self-Definition in Educational Contexts." In Schwind, J. & Lindsay, S. (Eds.). *From Experience is Relationships: Reconstructing Ourselves in Education and Healthcare*.

Man Lam, C., Wong, H., Tse Fong Leung, T. 2007. "An Unfinished Reflexive Journey: Social Work Students' Reflection on the Placement Experiences." *British Journal of Social Work*, 37 (1): 91-105.

Mattingly, C. 1998. *Healing Dramas and Clinical Plots: the Narrative Structure of Experience*. Cambridge University Press.

Mattingly, C. 2010. *The Paradox of Hope: Journeys Through a Clinical Borderland*. Berkeley: University of California Press.

McKechnie, R., Jaye, C., & MacLeod, R. 2010. "The Liminality of Palliative Care." *Sites: a Journal of Social Anthropology and Cultural Studies,* 7(2): 9-29.

McKenzie, P.J. and Carey, R.F. (2000). "What's Wrong with that Woman?" – Positioning Theory and Information-Seeking Behaviour. Accessed 5 April 2013 from www.cais-acsi.ca/proceedings/2000/mckenzie_2000.pdf.

McKenzie, V. 2007. "Liminal Space: Postgraduate Creative Writing in Australian Universities." *Liminal: A Journal of Historical and Cultural Studies*. Accessed 5 April 2013 from http://www.limina.arts.uwa.edu.au/__data/page/115716/McKenziefinal5.pdf

McNamee, S. & Hosking, D.M. 2011. *Research and Social Change: A Relational Constructionist Approach*. London: Routledge.

McNamee, S. 2000. "The Social Poetics of Relationally Engaged Research: Research as Conversation." In Deissler, K. & McNamee, S. (Eds.) *Philosophy in Therapy: the Social Poetics of Therapeutic Conversation*. Heidelberg: Carl-Auer-Systeme Verlag.

McNamee, S. 2004. "Promiscuity in the Practice of Family Therapy." *Journal of Family Therapy*, 26: 224–244.

McNamee, S. 2007. "Relational Practices in Education – Teaching as Conversation." In Anderson, H. & Gehart, D. (Eds.) *Collaborative Therapy: Relationships and Conversations that Make a Difference*. New York: Taylor and Francis.

McNamee, S. 2008. "Transformative Dialogue: Coordinating Conflicting Moralities: the Lindberg Lectures". Accessed 30 March 2013 from http://pubpages.unh.edu/~smcnamee/dialogue_and_transformation/LindbergPub2008.pdf.

McNamee, S. 2009. "Postmodern Psychotherapeutic Ethics: Relational Responsibility in Practice." *Human Systems: the Journal of Therapy, Consultation and Training*, 20(1): 57-71.

McNamee, S. 2012. "From Social Construction to Relational Construction: Practices from the Edge." *Psychological Studies*, April-June, 57(2): 150-156.

McNamee, S. 1996. "The Relational Construction of Being: Out of the Head and into the Discourse" (Draft). Accessed 30 March 2013 http://pubpages.unh.edu/~smcnamee/dialogue and transformation/index.html

Misra, G. & Prakash, A. 2012. "Kenneth J. Gergen and Social Constructionism." In *Psychological Studies,* April-June, 57(2): 121-125.

Monk, G. & Winslade, J. 2013. *When Stories Clash: Addressing Conflict with Narrative Mediation.* Ohio: Taos Institute Publications.

Montgomery, K. 1991. *Doctors' Stories: the Narrative Structure of Medical Knowledge*. Princeton University Press.

Moran, D. 2012. "Together and Waiting:." *Journal of Medical Humanities* 38: 37. Accessed 30 March 2013 from http://mh.bmj.com/content/38/1/37.extract

Morris, D. 2001. "Narrative, Ethics and Pain: Thinking with Stories." *Narrative,* 9(1), January 2001.

Mullavey-O'Byrne, C. & West, S. 2001. "Practising without Certainty: Providing Health Care in an Uncertain World." In Higgs, J. & Titchen, A. (Eds.), *Professional Practice in Health, Education and the Creative Arts.*

Myerhoff, B. 1978. *Number Our Days*. New York: Dutton Publishers.

Myerhoff, B. 1992. *Remembered Lives: the Work of Ritual, Storytelling and Growing Older,* Kaminsky, M. (Ed.). The University of Michigan Press.

Neilsen, L. 2004. "Aesthetics and Knowing: Ephemeral Principles for a Groundless Theory." In Cole, A. (Ed.). *Provoked by Art: Theorizing Arts-informed Research*. Halifax: Backalong Books.

Neilson, S. 2000. "Occasional Poetics." *Canadian Medical Association Journal*, 162(3): 377.

Nelson, H.L., 2001. *Damaged Identities: Narrative Repair.* New York: Cornell University Press.

Nicholas, B. & Gillett, G. 1997. "Doctors' Stories, Patients' Stories: a Narrative Approach to Teaching Medical Ethics." *Journal of Medical Ethics* 23: 295-299.

Nisker, J. 2008. "Calcedonies." In Nisker, J. (Ed.). *From the Other Side of the Fence: Stories from Health Care Professionals.* Halifax: Pottersfield Press.

Nisker, J. 2010. "Calcedonies: Critical Reflections of Writing Plays is Engage Citizens in Health and Social Policy Development." *Reflective Practice*, 11(4): 417-432.

Osipov, R. 2011. "Healing Narrative: Ethics and Writing about Patients." *American Medical Association Journal of Ethics,* 13(7): 420-424.

Pelias, R. 2011. Leaning: A Poetics of Personal Relations. Walnut Creek, California: Left Coast Press Inc.

Phillips, C. 2007. "Untitled Moments: theorizing incorporeal knowledge in social work practice." *Qualitative Social Work*, 6(4): 447-464.

Phillips, N. 1995. "Telling Organizational Tales: on the Role of Narrative Fiction in the Study of Organizations." *Organization Studies,* 16(4): 625-649.

Piirto, J. 2002. "The Question of Quality and Qualifications: Writing Inferior Poems as Qualitative Research." *Qualitative Studies in Education*, 15(4): 431-445.

Polkinghorne, D. 1997. "Reporting Qualitative Research as a Practice." In Tierney, W. & Lincoln, Y. (Eds), *Representation and the Text: ReFraming the Narrative Voice,* Albany: State University of New York Press.

Polkinghorne, J. 2001. "Novel Practices: Reading Groups and Narrative Ideas." *Gecko: A Journal of Deconstruction and Narrative Ideas in Therapeutic Practice*, No 3: 34-50.

Potteiger, M. & Purinton, J. 1998. *Landscape Narratives: Design Practices for Telling Stories.* New York: John Wiley & Sons.

Prendergast, M., Leggo, C. & Sameshima, P. 2009. *Poetic Inquiry: Vibrant Voices in the Social Sciences*. Sense Publishers.

Prior, L. 2004. "Documents." In Seale, C. et al (Eds.) *Qualitative Research Practice*. London: Sage Publications.

Priya, K.R. 2012. "Social Constructionist Approach to Suffering and Healing: Juxtaposing Cassell, Gergen and Kleinman." *Psychological Studies,* 57(2), April-June: 211-223.

Raingruber, B. 2004. "Using Poetry is Discover and Share Significant Meanings in Child and Adolescent Mental Health Nursing." *Journal of Child and Adolescent Psychiatric Nursing,* 17(1): 13-20.

Ramsey, C. 2011. "Poetry and the Creation of Relational Space: Conversations for Inquiry and Learning." *Tamara: Journal for Critical Organization Inquiry*, 9(1-2) March-June.

Rappaport, M. 2006. "The Poetry of Practice." *The International Journal of the Creative Arts in Interdisciplinary Practice,* 3. Accessed 5 April 2013 from http://www.ijcaip.com/archives/IJCAIP-8-Rappaport.html.

Rapport, F., Wainwright, P., & Elwyn, G. 2004. "The View from the Edgelands." *Journal of Medical Humanities*, 30(5): 5-6.

Rath, J. 2012. "Poetry and Participation: Scripting a Meaningful Research Text with Rape Crisis Workers." *Forum: Qualitative Social Research*, 13(1).

Rhodes, C. & Brown, A. 2005. "Writing Responsibly: Narrative Fiction and Organization Studies, *Organization*, 12(4): 467-491.

Richardson, L. 1992. "The Consequences of Poetic Representation: Writing the Other, Rewriting the Self." In Flaherty, M. & Ellis, C. (Eds.), *Investigating Subjectivity: Research on Lived Experience.* California: Sage Publication.

Richardson, L. 1994. "Writing: A Method of Inquiry." In Denzin, N. & Lincoln, Y. (Eds.), *Handbook of Qualitative Research* (First Edition), California: Sage Publications.

Richardson, L. 2001. "Getting Personal: Writing-Stories." *Qualitative Studies in Education*, 14(1): 33-38.

Richardson, L. 2010. "Academia: A Poetic Memoir." *Poetry and Education: Possibilities and Practices*, 4(1): 51-59.

Riessman, C.K. & Speedy, J. 2007. "Narrative Inquiry in the Psychotherapy Professions: A Critical Review." In Clandinin, D.J. (Ed.), *Handbook of Narrative Inquiry: Mapping a Methodology.* California: Sage Publications.

Rober, P. 2002. "Constructive Hypothesizing, Dialogic Understanding and the Therapist's Inner Conversation: Some Ideas about Knowing and Not Knowing in the Family Therapy Session." *Journal Marital and Family Therapy*, 28(4): 467-78.

Robson, L. 2008. "An Open Letter to My Patients." In Nisker, J. (Ed.). *From the Other Side of the Fence: Stories from Health Care Professionals*. Nova Scotia: Pottersfield Press.

Roscoe, K., Carson, M. & Madoc-Jones, L. 2011. "Narrative Social Work: Conversations Between Theory and Practice." *Journal of Social Work Practice*, 25(1): 47-61.

Rosen, K. 2009. Saved by a Poem: the Transformative Power of Words. Hay House Inc.

Rossiter, A. 2005. "Discourse Analysis in Critical Social Work: From Apology to Question." *Critical Social Work: an Interdisciplinary Journal*, 6(1).

Rossiter, A. 2007. "Self as Subjectivity: Toward a Use of Self as Respectful Relations of Recognition." In Mandell, D. (Ed.), *Revisiting the Use of Self: Questioning Professional Identities.* Canadian Scholars' Press.

Sands, S. et al. 2008. "Pediatric Narrative Oncology: Interprofessional Training to Promote Empathy, Build Teams and Prevent Burnout." *Supportive Oncology*, 6(7): 307-12.

Schaefer, J. (Ed.) 2006. *The Poetry of Nursing: Poems and Commentaries of Leading Nurse-Poets.* Ohio: Kent State University Press.

Schmidt, C. & Adkins, C. 2012. "Understanding, Valuing and Teaching Reflection in Counselor Education: A Phenomenological Inquiry." *Reflective Practice*, 13(1): 77-96.

Schoenwandt, J.M. 1999. "Toward a Feminist 'Third Space': Photographic 'Cites' of Cultural Transformation." Accessed 5 April 2013 from http://digitool.Library.McGill.CA:80/R/-?func=dbin-jump-full&object_id=37725&silo_library=GEN01.

Schon, D.A. 1987. *Educating the Reflective Practitioner*. San Francisco: Jossey-Bass Publishers.

Schwind, J. & Lindsay, G. (Eds.). 2008. *From Experience to Relationships: Reconstructing Ourselves in Education and Healthcare.*

Schwind, J. 2009. "Metaphor-Reflection in My Healthcare Experience." *Aporia: The Nursing Journal*, 1(1): 15-21.

Sergi, P. & Gorman, G. (Eds.). 2009. *A Call to Nursing: Stories about Challenge and Commitment.* New York: Kaplan Publishing.

Serviss, S. 2005. *Hitchhiking in the Hospital.* Edmonton: Inking press.

Serviss, S. 2007. "Poetry as Contingency." *MUSA: University of Alberta Health Sciences Journal*, September, 4(1): 24.

Shah, S. 2009. "Writing Medicine: Narrative and Literature Helps Community Members Express Personal Stories of Chronic Illness." *International Journal of the Creative Arts in Interdisciplinary Practice*. Accessed 5 April 2013 from http://www.ijcaip.com/archives/IJCAIP-8-Shah.html.

Shalof, T. 2005. *A Nurse's Story.* Toronto: McClelland and Stewart.

Shapiro, J. 2011. "Illness Narratives: Reliability, Authenticity and the Empathic Witness." *Medical Humanities* (37): 68-72.

Sheppard, M., Newstead, S., Di Caccavo, A. & Ryan, K. 2000. "Reflexivity and the Development of Process Knowledge in Social Work: A Classification and Empirical Study." *British Journal of Social Work,* (30): 465-488.

Shotter, J. & Katz, A. 1999. "'Living Moments' in Dialogical Exchanges." *Human Systems,* 9: 81-93.

Shotter, J. 2010. *Social Construction on the Edge: "Withness" Thinking & Embodiment*. Taos Institute Publications.

Sibbett, C. & Thompson, W. 2008. "Nettlesome Knowledge, Liminality and the Taboo in Cancer and Art Therapy Experiences: Implications for Teaching and Learning." In Land, R., Meyer J.H.F. & Smith J. (Eds.), *Threshold Concepts within the Disciplines*. Sense Publishers.

Sibbett, C. 2004. "Liminality: Living and Practising at the Threshold." *Making Sense of Health, Illness and Disease Conference*, Oxford. Accessed 5 April 2013 from http://www.inter-disciplinary.net/ptb/mso/hid/hid3/sibbett%20paper.pdf.

Sikes, P. 2010. "The Ethics of Writing Life Histories and Narratives in Educational Research." In *Exploring Learning, Identity and Power through Life History and Narrative Research.* London: Routledge.

Silverman, R. 2001. "The 'In between.'" Limen: Journal for Theory and Practice of Liminal Phenomena, 1.

Simon, G. 2013. "Relational Ethnography: Writing and Reading in Research Relationships." *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research,* 14(1). Accessed 30 March 2013 from http://www.qualitative-research.net/index.php/fqs/article/view/1735/3457.

Smith, B. & Sparkes, A. 2008. "Contrasting Perspectives on Narrating Selves and Identities: an Invitation is Dialogue." *Qualitative Research* 8(1): 5-35.

Smith, C. 2001. "The Space of Liminality and the Space of Architecture." *Limen: Journal for Theory and Practice of Liminal Phenomena.* Accessed 30 March 2013 from http://limen.mi2.hr/limen1-2001/catherine smith.html.

Sojo, E. 1996. *Thirdspace: Journeys to Los Angeles and Other Real-and-Imagined Places*. Oxford: Wiley Blackwell.

Sontag, S. 1978. *Illness as Metaphor.* New York: Farrar, Strauss & Giroux.

Sparkes, A. 2007. "Embodiment, academics, and the audit culture: a story seeking consideration." *Qualitative Research* 7(4): 521-550.

Speedy, J. 2000. "The 'Storied Helper': Narrative Ideas and Practices in Counseling and Psychotherapy." *European Journal of Psychotherapy, Counselling and Health*, 3(3): 361-374.

Speedy, J. 2002. "Writing At the Interface of Therapy, Academic and Community Education Cultures." *International Journal of Narrative Therapy and Community Work*. No 4, Adelaide: Dulwich Centre Publications.

Spence, D. 1982. *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis*. New York: W.W. Norton & Company.

St. Pierre, E.A. 2007. "Writing as Method." *Blackwell Encyclopedia of Sociology*. Ritzer, G. (Ed.). Blackwell Reference Online. Accessed 30 March 2013 from www.blackwellreference.com/public/.

Stacey, G. & Hardy, P. 2011. "Challenging the Shock of Reality Through Digital Storytelling." *Nurse Education in Practice,* 11(2): 159-64.

Stein, H.F. 1990. "The Story Behind the Clinical Story: an Inquiry into Biomedical Narrative." *Family Systems Medicine*, 8(2): 213-227.

Stein, H.F. 2006. "Clinical Poems and Clinical Conversations: Some Thoughts on Working with Family Medicine Residents." *Journal for Learning through the Arts* 2(1). Accessed 5 April 2013 from http://escholarship.org/uc/item/0d03228w.

Stein, H.F. 2007. *Insight and Imagination: A Study of Knowing and Not-Knowing in Organizational Life*. Maryland: University Press of America Inc.

Stein, H.F. 2011. *In the Shadow of Asclepius: Poems from American Medicine*. Indianapolis: Dog Ear Publishing.

Stewart, S. 2010. "The Grief Beneath Your Mothertongue: Listening through Poetic Inquiry." *Poetry and Education: Possibilities and Practices*. 4(1). Accessed 5 April 2013 from http://www.learninglandscapes.ca/archives/76-autumn-2010-vol4-no1-poetry-and-education-possibilities-and-practices.

Strong, T. 2012. "Talking about the DSM-V." Paper presented to the Therapeutic Conversations X Conference, Vancouver, Canada, 12 May 2012. Accessed 5 April 2013 from http://www.taosinstitute.net/Websites/taos/images/ResourcesManuscripts/Strong_Talking_about_the_DSM-V.pdf.

Swartz, S. 2006. "The Third Voice: Writing Case Notes." *Feminism and Psychology*, 14(4): 427-444.

Swenson, C. 2004. "Dementia Diary: a Personal and Professional Journal." *Social Work,* 49(3): 451-60.

Swim, S., St. George, S., Wulff, D. 2001. "Process Ethics: A Collaborative Partnership." *Journal of Systemic Therapies*, 20(4): 14-24.

Swisher, L.L., 2002. "A Retrospective Analysis of Ethics Knowledge in the Physical Therapy: 1970-2000." *Physical Therapy: Journal of the American Physical Therapy Association*, 82: 692-706.

Taiwo, A. 2011. "Relational Poetry in the Expression of Social Identity: Creating Interweaving Dialogue." *Qualitative Social Work*. Accessed 5 April 2013 from http://qsw.sagepub.com/content/early/2011/09/28/1473325011425892.abstract?rss=1.

Tamas, S. 2009. "Writing and Righting Trauma: Troubling the Autoethnographic Voice." *Forum: Qualitative Social Research*, 10(1): Art 22. Accessed 5 April 2013 from http://nbn-resolving.de/urn:nbn:de:0114-fqs0901220.

Todres, L. & Galvin, K. 2008. "Embodied Interpretation: A Novel Way of Evocatively Re-Presenting Meanings in Phenomenological Research." *Qualitative Research*, 8 (5): 568-583.

Trahar, S. 2009. "Beyond the Story Itself: Narrative Inquiry and Autoethnography in Intercultural Research in Higher Education." *Forum: Qualitative Studies*, 10(1), Art. 30. Accessed 5 April 2013 from http://nbn-resolving.de/urn:nbn:de:0114-fqs0901308.

Transken, S. 2002. "Poetically Teaching/Doing the Profession of Social Work as a Joyful Undisciplined Discipline-Jumper and Genre-Jumper." *Critical Social Work*, 3 (1). Accessed 5 April 2013 from http://www.uwindsor.ca/criticalsocialwork/2002-volume-3-no-1

Triezenberg, H.L. & McGrath, J. 2001. "The Use of Narrative in an Applied Ethics Course for Physical Therapist Students." *Journal of Physical Therapy Education*, 15(3): 49-56.

Turner, V. 1969. "Liminality and Communitas." In *The Ritual Process: Structure and Anti-Structure.* London: Routledge and Kegan Paul Publishers.

Turner, V. 1987. "Betwixt and Between: the Liminal Period in Rites of Passage." In *Betwixt and Between: Patterns of Masculine and Feminine Initiation.* Chicago: Open Court Publishing.

Vaughan, K. 2005. "Pieced Together: Collage as an Artist's Method for Interdisciplinary Research." *International Journal of Qualitative Methods*, 4(1): 1-20.

Vickers, M. 2002. "Researchers as Storytellers: Writing On the Edge – and Without A Safety Net." *Qualitative Inquiry*, 8(5): 608-621.

Wang, D. 2012. "The Use of Self and Reflective Practice in Relational Teaching and Adult Learning: A Social Work Perspective." *Reflective Practice* 13(1): 55-63.

Warnock, T. 2000. "Language and Literature as 'Equipment for Living'." In Anderson, C. & MacCurdy, M. (Eds.), *Writing and Healing: Toward an Informed Practice*. Illinois: National Council of Teachers of English.

Watts, D. 2000. "Audio Commentary on 'Physical Exam,'" Literature, Arts & Medicine database. Accessed April 5 2013 from http://litmed.med.nyu.edu/poems/comm.physical.exam.dw.aif.

Weick, A. 1999. "Guilty Knowledge." Families in Society: the Journal of Contemporary Human Services, 80(4): 327-332.

Wellbery, C. 2010. "The Value of Medical Uncertainty?" *The Lancet*, 375(9727): 1686 - 1687.

White, M. 2002. "Journey Metaphors." *The International Journal of Narrative Therapy and Community Work*, No 4. Adelaide: Dulwich Centre Publications.

White, M. 2010. *Narratives of Therapists' Lives*. Nabu Public Domain Reprints.

Whitt, L.A. 2001. "Belonging/Between." *Limen: Journal for Theory and Practice of Liminal Phenomenon*. Accessed 7 April 2013 from http://limen.mi2.hr/limen2-2001/whitt.html.

Whitt, L.A. 2001. "Surrounding Stories." *Limen: Journal for Theory and Practice of Liminal Phenomenon*. Accessed 7 April 2013 from http://limen.mi2.hr/limen2-2001/whitt.html.

Wilder Craig, R. 2007. "A Day in the Life of a Hospital Social Worker: Presenting our Role Through the Personal Narrative." *Qualitative Social Work,* 6(4): 431-446.

Wilkinson, P. & Bissell, G. 2008. "Physical Boundaries and Professional Space: Social Work in Health Service Inter-professional Settings." *Critical Social Work: an Interdisciplinary Journal*, 9(1).

Williams, W.C. 1951. *The Autobiography of William Carlos Williams*. New York: Random House.

Winslade, J. 2002. "Storying Professional Identity." *the International Journal of Narrative Therapy and Community Work,* No 4. Adelaide: Dulwich Centre Publications.

Witkin, S. 2007. "Relational Poetry: Expressing Interweaving Realities." *Qualitative Social Work*. 477-481.

Wittgenstein, L. 1995. "On Certainty." In Jonathan Westphal, Ed. *Certainty.* Indiana: Hackett Publishing.

Wright, R.R., et al. 2010. "Rhyme, Response and Reflection: an Investigation of the Possibilities for Critical Transformative Learning through Adult Poetry Reading." *Journal of Transformative Education*, 8(2): 103-123.

Yardley, A. 2008. "Piecing Together – A Methodological Bricolage." *Forum: Qualitative Social Research*, 9(2). Accessed 5 April 2013 from http://nbn-resolving.de/urn:nbn:de:0114-fqs0802315.

Zandee, D. & Broekhuijsen, M. 2009. "Will it Work? Theatrical Rehearsal as Relational Form Giving Process." *NRI Research Paper Series* No 09-19. Accessed 5 April 2013 from http://www.nyenrode.nl/FacultyResearch/research/Documents/Research%20Paper%20Series/2009/NRI%2009-19%20Danielle%20Zandee%20and%20Marijke%20Broekhuijsen.pdf.